Group Member Guide
2021

COMMUNITY
Health Options™

Table of Contents

▶ CLICK ON ANY TITLE TO JUMP TO THAT SECTION

Community Health Options Overview

Founded in 2011 and located in Lewiston, Maine, Community Health Options (Health Options), is a health insurance pioneer that has your back. We are a local, nonprofit option that was created to serve Members, not profit off them. We strive to keep costs low, while providing the benefits you deserve.

We are one of Maine's largest carriers for the individual health insurance market and proudly partner with more than 1,300 businesses, a number that continues to grow. We have a robust network of 48,000 providers in New England with a supplemental network providing national coverage within our employer group plans. With a high retention rate within our employer group business, high recommendation rates from our brokers, and high Member service scores, we are proud to know that Health Options is delivering excellence for all our partners.

Partner with more than 1,300 businesses

Network of 48,000 providers in New England

PLUS a supplemental network providing national coverage within our employer group plans

Overview of Group Benefits

Welcome to Community Health Options! We are happy to have you as a Member. Once you have enrolled, getting the most from your plan begins with understanding your benefits and services. We want our Members to get optimal care at the best prices, and our team is ready to help you at every step of this process.

Most of our plans include the following:

Pharmacy benefit manager Express Scripts Inc., to support the filling of prescriptions by mail for **home delivery** or through retail pharmacies.

100% of the preventive care benefits required by the Affordable Care Act and the State of Maine.

Full coverage for a flu vaccination at in-network providers each flu season for all adult and pediatric Members.

COVID-19 Vaccination and COVID-19 Testing as recommended by a healthcare provider are covered with no cost-sharing.

One routine eye exam every 12-calendar-month period for pediatrics and adults. Coverage for glasses and contacts every 24-calendar- month period is available on some plans. Co-pays, deductibles and co-insurance may apply.

Tobacco Cessation Support: An enhanced benefit for over-the-counter nicotine replacement therapy (NRT) products, including nicotine patches, gum, lozenges, and certain FDA-approved medications listed on our drug formulary.

The first three in-network outpatient Behavioral Health visits with no cost-share on non-HSA compatible plans.

Coverage for **chiropractic and osteopathic manipulative therapy** on all plans.

Free phone support and personalized help with complex medical conditions from our Care Management team.

Chronic Illness Support Program (CISP) on select plans to reduce financial barriers for Members with asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, hypertension.

Healthwise®, a webite containing educational materials such as videos, articles and interactive questionnaires on a large variety of health related topics included on all plans.

*For more detailed information about our health plans or to review our Member Benefit Agreement and Schedule of Benefits, Provider Directory, Prescription Formulary or Privacy Notice, please visit our website at **healthoptions.org**. If you do not have access to a computer or internet services, please call (855) 624-6463.*

Finding Important Information About Your Plan

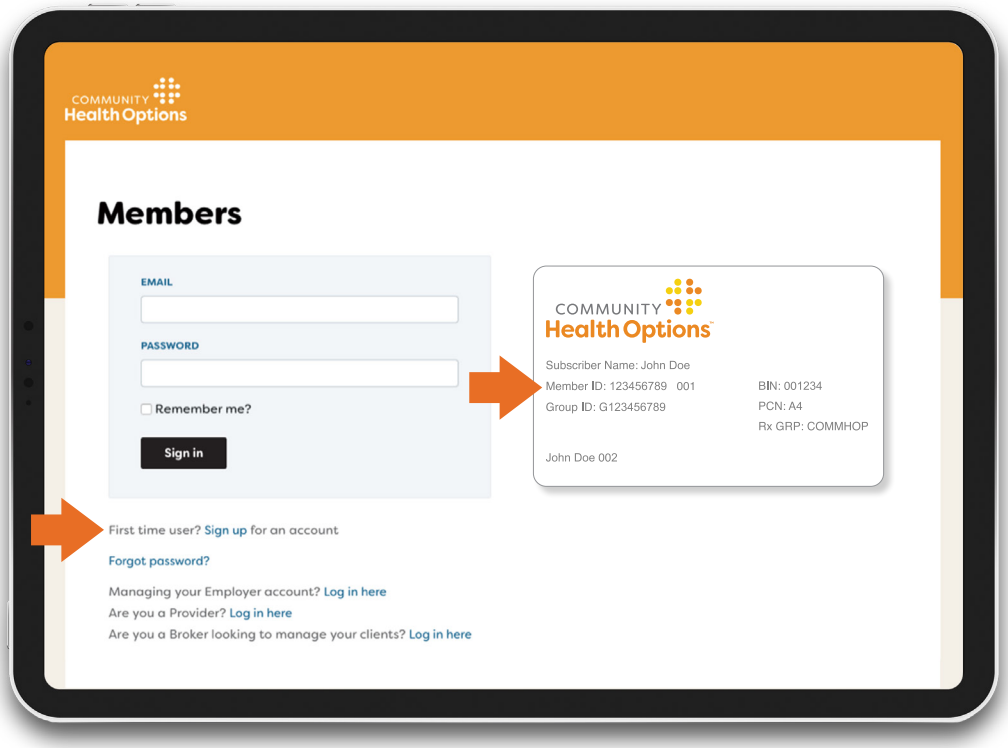
Upon enrollment, Members will receive a welcome letter that includes a Member ID card and instructions on setting up the Member online portal. The online Member portal provides access to your plan benefits, claims, paperless delivery, primary care provider (PCP)/pediatrician (PED) selection and more. A personal health information (PHI) release form is also included. This allows Health Options to release your personal health information to the person designated on the form. The PHI release form is optional and only needs to be completed if you would like to designate someone else to receive PHI.

Getting Started Online: Your Portal

The portal has everything you need to get started with your new benefits plan. Setting up your **secure, personal Member portal** takes just a few minutes and gives you **24/7 online access** to your plan benefits and documents.

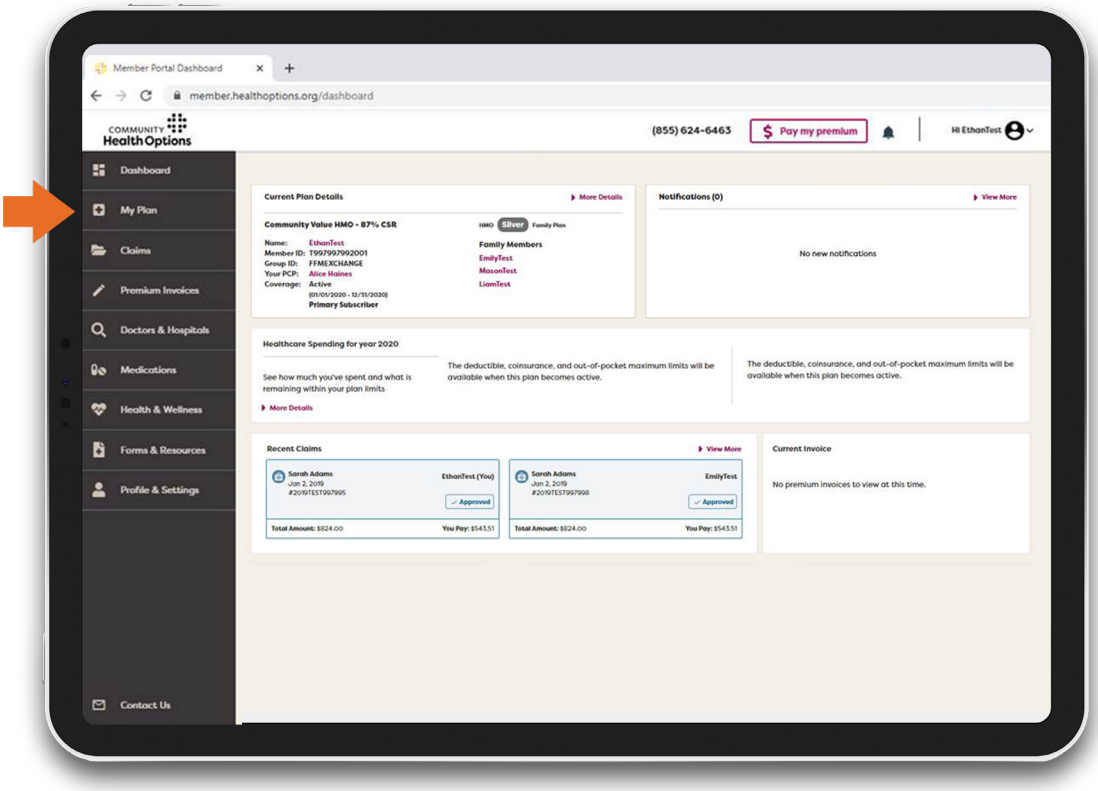
HERE'S HOW TO GET STARTED:

- Go to **healthoptions.org**.
- Click on **Sign In** at the far right corner of the screen.
- Select **Member Login**
- Click on **First Time User? Sign up for an account**.
- At the next screen, enter your Member ID number, last name and date of birth (see illustration below).



Get to Know Your Dashboard

Once you set up your account, your **portal** displays your personal dashboard and **loads your benefit plan** when you go to **My Plan** on the left side menu.



Go to the My Plan section on the left side menu and click on Check What's Covered to see:

MEMBER BENEFIT AGREEMENT

Your contract with Health Options, which specifies the services covered under your plan.

SUMMARY OF BENEFITS AND COVERAGE

Provides an overview of your plan benefits, including your out-of-pocket costs.

SCHEDULE OF BENEFITS

A summary of services, benefit limits, and cost-sharing responsibilities under your health plan.

Get to Know Your Dashboard (continued)

More ways to use the dashboard to manage your benefits.

CHOOSE OR CONFIRM A PRIMARY CARE PROVIDER (PCP) OR PEDIATRICIAN (PED)

Selecting a PCP/PED

- Search for a provider by going to the **Doctors & Hospitals** section of the dashboard.
- Click **Find a doctor or hospital**. Enter your search criteria and a list of the provider's accepting new members will appear.
- Choose a provider and then click the **Select as a PCP** button for a PCP or PED.

Confirming a PCP or PED

- Review the PCP or PED name that appears on your dashboard.
- To change the provider, click on the provider's name and you will see the **Change PCP** button. This button will apply to a PED as well. If you have any trouble, please call Member services at (855) 624-6463.

ACTIVATE YOUR EXPRESS SCRIPTS ONLINE PORTAL

- Express Scripts, our pharmacy benefits partner, provides help with prescription-related information and services through its own website.
- Register with Express Scripts by going to the portal's Medications section and clicking **Get started / Log in.**

STAY INFORMED

- See a list of Preventive Health Care Benefits.
- Access our FAQs and resource library for useful information.
- Read the latest Health Options news.
- Link to Healthwise to navigate to health education articles, videos, and interactive questionnaires.

GO PAPERLESS NOW

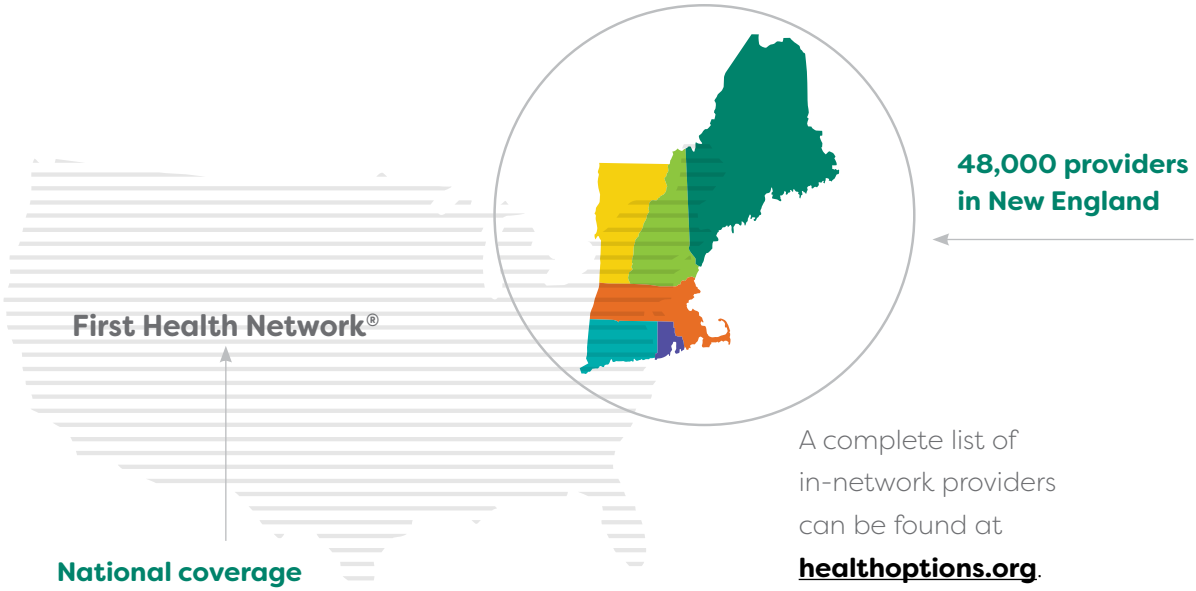
- Get ready today for electronic delivery of documents. In June 2021 we'll be delivering plan documents like explanation of benefits (EOB), and prior authorization letters electronically. It's simple, secure and convenient. Plus you can check your claims, see updates and more.

Can't find what you need?

Our Member Services Associates can help when you can't access our website or just want to talk to an expert. Give them a call with your questions, (855) 624-6463, Monday – Friday 8:00 a.m. to 6:00 p.m. or email the team at this **email form**.

Network Providers

Health Options has a robust network of providers designed to make it easy and convenient for Members to receive care. Our network includes 48,000 providers in New England. Group Members spending time outside of Maine and New Hampshire can count on national coverage through **First Health Network®**.



A complete list of in-network providers can be found at **healthoptions.org**.

MEMBER NETWORK BY GEOGRAPHIC LOCATION			
Service Type	**Within ME/NH**	**Within MA/VT**	**Outside ME, NH**
Medical/Behavioral Health, Substance Use Disorder	Community Health Options' Service Area Network is broad within ME & NH	Community Health Options' Service Area Network is supplemented by First Health Network	First Health Network and contracted hospitals
Pharmacy	Express Scripts National Pharmacy Network includes most national and local pharmacies	Express Scripts National Pharmacy Network includes most national and local pharmacies	Express Scripts National Pharmacy Network includes most national and local pharmacies

While our network comprises **100% of hospitals in Maine and most in New Hampshire**, it extends well beyond these states, including many premier institutions within New England.

- Dana Farber Cancer Institute
- Massachusetts General
- Brigham and Women's Hospital
- Brigham and Women's Faulkner Hospital
- Boston Children's Hospital
- Dartmouth-Hitchcock
- Newton-Wellesley Hospital
- North Shore Medical Center, Spaulding Hospital
- Springfield Hospital

Network Providers

Finding the Care You Need

Use this guide for tips on getting the care you need when and where you need it.

SELECTING A PRIMARY CARE PROVIDER (PCP) OR PEDIATRICIAN (PED)

You can find and select a PCP or PED in your Member portal for you and your dependents. To make sure you are finding a provider that fits your needs:

- Ask the PCP/PED about office hours and whom to contact after hours.
- Check how long it will take to obtain an appointment, and whether the provider will speak with you over the phone.
- Ask how long a typical waiting room time is.
- If you need help selecting a PCP/PED, contact Member Services at (855) 624-6463.

BEFORE YOUR PCP VISIT

- Review your Summary of Benefits & Coverage to confirm your cost share for a PCP visit.
- Be prepared to pay on the day of your appointment.
- Plan preventive care visits with in-network PCP/PED providers based on the recommendations included at healthcare.gov. They are covered with no cost-share. Note: tests and additional services provided during the visit may be subject to a routine cost-share.

Network Providers

More questions about where to go for care? Use this chart to make the best choices based on your healthcare needs – and save money in the process.

WHERE TO GO FOR CARE		
Healthcare Service	**When & Why To Choose This Option**	**Typical Expense**
Primary Care Provider (PCP)/ Pediatrician (PED) *The doctor, physician assistant, or nurse practitioner you chose when your Health Options coverage began*	**Call or visit your PCP/PED for:** • Regular well checks • Preventive services • Minor skin conditions • Cold- and flu-related symptoms • Referrals to specialists • Assessing medical conditions or concerns • Vaccinations • General health management of chronic conditions	$
Walk-in Primary Care Service *These facilities are associated with a PCP practice and have extended hours and walk-in service*	**Use Walk-in Primary Care when you need quick care for non-life threatening conditions.** • Sprains • Minor injuries that require stitches • Minor burns • Minor broken bones • Minor infections • Cold, flu, strep symptoms • Respiratory infections	$-$$ (Costs may vary but will generally be less expensive than the Emergency Department of a hospital.)
Urgent Care *These are stand-alone, walk-in clinics*	**Go to an Urgent Care Center when you need quick care for non-life-threatening conditions.** • Sprains • Minor injuries that require stitches • Minor burns • Minor broken bones • Minor infections • Cold, flu, strep symptoms • Respiratory infections	$$
Emergency Department (ED) at a hospital	**Go to the ED or call 911 for serious, life-threatening injuries or conditions:** • Large open wounds • Heavy bleeding • Chest pains • Sudden weakness or trouble talking • Major burns • Severe head injuries • Major broken bones • Difficulty breathing	$$$

Questions?

Call Member Services (855) 624-6463, Monday through Friday, 8:00 a.m. – 6:00 p.m., or **email** the team.

Preventive Care

Health Options has your back when it comes to preventive health and wellness. Many preventive healthcare services, including screenings, check-ups, and counseling, **have no cost-share**.

We offer **100% of the preventive care benefits** required by the Affordable Care Act and the State of Maine. Services defined in the federal law that meet the criteria of preventive care and are administered by in-network providers are covered with no cost-share.

Preventing influenza is important to Health Options, which is why we provide full coverage for a flu vaccination at in-network providers (doctors or pharmacies*) each flu season for all adult and pediatric Members.

Through the **COVID-19 health emergency**, there is no cost-share for COVID-19 vaccinations, provider-recommended COVID-19 testing, and associated lab processing fees, the office, ER, or urgent care visit to collect the specimen, as well as COVID-19 telehealth screening services with your provider's office.

Preventive screenings identify diseases or medical conditions before any signs or symptoms are present, enabling early diagnosis of health problems. Preventive screenings do not include tests or services to monitor or manage a condition or disease once it has been diagnosed.

Preventive counseling usually occurs when a person has been identified (but not yet diagnosed) as being at risk for a specific disease or medical condition at a preventive screening. Preventive counseling and intervention are intended to provide basic information about a medical condition and help you develop the skills to manage health.

**For children aged 9 or older, flu vaccines are covered at in-network pharmacies and not "minute clinics" within pharmacies. Call ahead to confirm availability.*

Preventive Care

Diagnostic versus Preventive Services:

A **diagnostic** service is performed to evaluate and determine treatment for new symptoms or to monitor **existing conditions**. Diagnostic services help the provider diagnose an illness and offer an opportunity for the provider to discuss the best course of treatment. These services are subject to routine cost-share.

Preventive services include screenings that are provided when you or your family member are symptom-free and have no reason to believe you might be unhealthy. Many times, preventive screenings are recommended for a specific population and are provided as part of a routine physical or check-up. Preventive screenings outlined in the Affordable Care Act (ACA) at **healthcare.gov** are covered with no cost-share.

Some services performed during or related to an annual preventive exam, such as lab tests or diagnostic procedures, may not be covered as a preventive service and are subject to routine cost share.

If the provider recommends a service or test, it's helpful to ask the provider:

- What is the test for?
- Why is this service needed?
- Are there any alternatives?
- What are the possible complications?

If you have questions about how services are covered, contact Member Services (855) 624-6463, Monday through Friday, 8:00 a.m. – 6:00 p.m. or **email** the team.

Preventive Care

Commonly Asked Preventive Services Questions

Where can I find a list of the preventive services that are covered with no out-of-pocket cost?

Visit **healthcare.gov** to search on preventive services for adults, children or women.* In addition, the following services are covered:

- Routine immunizations for children, adolescents, and adults that are recommended by the Center for Disease Control Preventive Advisory Committee on Immunization Practices; and
- Services for women, infants, children and adolescents that are further outlined by the Health Resources and Services Administration.

What immunizations are covered as a preventive service?

Routine immunizations listed on the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices website are covered for children, adolescents and adults.

- Many childhood (age 18 or younger) vaccinations, including HPV for boys and girls, are covered. A listing of **child and adolescent routine immunizations** (age 18 or younger) may be found **here**.
- A listing of **adult routine immunizations** may be found **here**.

Are lab tests covered as a preventive service?

Generally, routine lab tests, such as a complete blood count (CBC), Lyme disease, Vitamin D or thyroid tests are not covered as preventive services, and they are subject to routine cost share. Screening tests, such as some cholesterol and blood sugar, are covered with no cost-share based on age and certain risk factors. Preventive Service lab tests can be found at **healthcare.gov**, or by visiting one of the resources listed below:

- Visit the Women's Preventive Services Guidelines by clicking **here**.
- Visit the Preventive Pediatric Healthcare Recommendations from healthcare.gov by clicking **here**.

**New guidelines may be published. The timing of coverage is generally applied to a future date. For example, a recommended service release date in March 2021 may not be covered as a preventive service until 2023.*

Wellness Benefits

Wellness is our priority, which is why our benefits focus on easy access and affordability for the care Members need.

Tobacco Cessation Support

We offer an **enhanced benefit** for over-the-counter nicotine replacement therapy (NRT) products, including nicotine patches, gum, lozenges, and certain FDA-approved medications listed on our drug formulary.

Telehealth for Provider Visits

A provider visit can be just a click away. Health Options removes obstacles that may keep Members from accessing the healthcare needed. If the Provider offers the service, Members can use a video-conferencing telehealth visit via the internet, and the visit will have the same plan coverage as in-network or out-of-network provider office visits.

Behavioral Health

Health Options is committed to prioritizing emotional wellbeing along with physical health. The **first three in-network outpatient Behavioral Health visits for Members or dependents have no cost-share** on non-HSA compatible plans. In fact, Health Options will cover a medical visit and a behavioral health visit on the same day, and we can facilitate same-day referrals. We want our Members to reach out and get help as soon as they need it.

We offer telehealth psychiatry and counseling/therapy through a partnership with Amwell®, a company offering online provider visits 24/7. This option makes it easy and fast for Members and dependents to access care. Using these services is simple:

- In your Member portal, click on **Health & Wellness.**
- Click on **Learn More** under the HealthOptionsOnline section.
- Continue to the **Log in** section.
- You'll be redirected to the Amwell portal for registration.
- Follow the simple prompts to get started.

Some typical telehealth services include:

- Psychiatric review of behavioral health concerns, substance use disorders, and medication management.
- Behavioral health counseling or therapy services for mental health and substance use disorders.

Note: Telehealth through Amwell is not a crisis support service.

Wellness Benefits

LifeBalance

We believe that both physical health and emotional wellness contribute to your whole well-being. Our partnership with LifeBalance offers Members discounted access to recreational, cultural, wellness, and travel opportunities in Maine and beyond, including:

- Bowling
- Theater
- Cinemas
- Hotels and Lodging
- Fitness Centers & Gyms
- Sporting Events
- Yoga classes
- Ski lift passes

HOW DOES LIFEBALANCE WORK?

The Health Options Member portal links to the LifeBalance website. It lists everything needed to locate and use discounts.

- Members are required to have an email address to access the program.
- It's easy to browse to find a benefit – exercise, nutrition, stress relief. It's self-care for all, regardless of age, income, ability, or interests.
- Most discounts are redeemed by showing certificates (on a mobile device or print-out) at our partnering businesses.

Questions?

Call LifeBalance Member Services from 12:00 noon–8 p.m. at (888) 754-5433 or email **info@LifeBalanceProgram.com**.

Wellness Benefits

Chiropractic and Osteopathic Manipulative Coverage

All plans include coverage for chiropractic and osteopathic manipulative therapy. Some plans require co-pays, while others require satisfying a deductible first. Prior approval is required for some services, (e.g., advanced imaging such as MRIs) ordered by a provider.

Refer to plan details or call Member Services at (855) 624-6453 for more information.

Vision

All group plans offer adult and pediatric vision coverage for one routine eye exam per 12-calendar-month period with a co-pay or deductible and co-insurance. Coverage for glasses and contacts for pediatrics are included on all plans as well as for adults on select plans (every 24-calendar-month period) with varying co-insurance, co-payment, or deductible requirements.

Oral Health

Health Options partners with Northeast Delta Dental (NEDD) to provide dental coverage for pediatric Members in our small employer group plans. A special dental deductible applies. Many large employer group plans contract with NEDD to offer both pediatric and adult coverage. See your plan details or call Member Services at (855) 624-6463 for more details.

Chronic Illness Support Program (CISP)

Select plans include our Chronic Illness Support Program (CISP), designed to improve the health of Members with chronic conditions. CISP saves Members money, contributes to the healthy maintenance of chronic illnesses, and helps reduce medical complications and unnecessary hospitalizations associated with many chronic illnesses.

For CISP-eligible plans, Members with **asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, and hypertension** who manage their conditions through in-network office visits and prescriptions have access to savings on routine care. **In order to maximize savings under this benefit, CISP medications must be obtained through the Express Scripts home delivery pharmacy**.

Benefits include:

- **$0 cost through home delivery for specific Tier 1 generic medications** used to treat the chronic illness
- **50% reduction in cost-share through home delivery for select Tier 2 and 3 medications** (preferred brand medications used to treat the chronic illness and deductible is waived)
- **Medical services at no cost-share** when performed by a network provider for the following services (unless otherwise noted)

CHRONIC ILLNESS SUPPORT PROGRAM (CISP) MEDICAL SERVICES				
Asthma	**Coronary Artery Disease (CAD)**	**Chronic Obstructive Pulmonary Disease (COPD)**	**Diabetes**	**Hypertension**
Office visits to the following providers: • Primary Care Provider, Pulmonologist, Allergist for routine management of asthma • Palliative care conversations with provider to discuss chronic condition treatment • Immunotherapy for allergen sensitization **Also covered:** • Inhaler adjuncts (e.g., holding chamber/spacer) through mail order • Pulmonary function tests • Allergy sensitivity testing • Asthma education • Targeted laboratory tests for the routine management of asthma	**Office visits to the following providers:** • Primary Care Provider, Cardiologist for routine management of CAD • Palliative care conversations with provider to discuss chronic condition treatment **Also covered:** • Electrocardiogram (ECG) • Nutritional counseling, up to six (6) visits per year • Cardiac rehabilitation and associated exercise programs are covered at 50% cost-share reduction. • Targeted laboratory tests for the routine maintenance of CAD	**Office visits to the following providers:** • Primary Care Provider, Pulmonologist for routine management of COPD • Palliative care conversations with provider to discuss chronic condition treatment **Also covered:** • Inhaler adjuncts (e.g. holding chamber/spacer) through mail order • Pulmonary function tests • Home oxygen therapy assessment • Pulmonary rehabilitation and associated exercise program are covered at 50% cost share reduction • Targeted laboratory tests for the routine management of COPD **Note that oxygen delivery and supplies are subject to routine coverage**	**Office visits to the following providers:** • Primary Care Provider, Endocrinologist, Podiatrist, Optometrist/ Ophthalmologist for routine management of diabetes • Palliative care conversations with provider to discuss chronic condition treatment **Also Covered:** • Nutritional counseling, up to six (6) visits per year • Diabetes education with a certified diabetes educator • Targeted laboratory tests for the routine management of diabetes **Diabetic supplies specified on the formulary and dispensed via ESI home delivery are covered at $0 cost-share:** • One glucometer per year • Glucose test strips: up to 150 strips every 30 days or 450 strips every 90 days **Note that Insulin pumps and continuous glucose monitors and associated supplies are subject to routine coverage**	**Office visits to the following providers:** • Primary Care Provider for routine management of hypertension • Cardiologist and Nephrologist for consultation and routine hypertension management • Palliative care conversations with provider to discuss chronic condition treatment **Also Covered:** • Nutritional Counseling, up to six (6) visits per year • Targeted laboratory tests for the routine management of hypertension

Pharmacy Management

Our in-house pharmacists support the development of a competitive and cost-effective prescription drug formulary in partnership with our Pharmacy Benefits Manager (PBM), Express Scripts Inc. They have designed an easy-to-use formulary with five tiers based on cost. For more information on co-pays by tier go to your Member portal or see plan details at **healthoptions.org**.

PRESCRIPTION DRUG FORMULARY TIERS	
TIER 1	Preferred Generics
TIER 2	Generics
TIER 3	Preferred Brand
TIER 4	Non-Preferred Brand
TIER 5	Specialty

Special Insulin Provision

Beginning with new enrollments and renewals effective with a 2021 start date, Members requiring insulin will have a cost-share not to exceed $35 for up to a 30-day supply.

ACA Preventive Drug Coverage

Under the Affordable Care Act (ACA), pharmacy benefits cover certain categories of preventive care drugs and products at 100% in all plans. This means there is no cost-share (deductible, co-payment or co-insurance). These drugs will be designated with ACA on the formulary. To view the ACA included medications, visit the Member portal or **click here** to go to the formulary.

HSA Preventive Drug Coverage

All group HSA Plans include a carefully created list of drugs containing medications to help prevent the development of and reduce the risk of complications due to chronic conditions and illnesses. These prescription drugs are identified on the formulary with an H.S.A notation. These drugs indicated with an H.S.A. designation bypass the deductible. Members pay only the applicable co-insurance or co-payment amounts. To view the H.S.A. designated drugs, visit the Member Portal or **healthoptions.org** to go to the formulary. Details on specific formulary coverage will be available in the Member portal.

> 100% of Members being treated for asthma with less than a 75% adherence rate with their inhaled controllers have been reached to provide education and assistance in removing barriers to adherence.

(Jan-Dec 2020)

Pharmacy Management

Pharmacy Benefit Manager

Our pharmacy benefit manager, Express Scripts, offers a portal that gives Members a high degree of control over prescription ordering and prescription costs with auto-generated comparisons and suggestions for lower cost prescription options. In a recent prescription drug utilization review, our team found that 90% of filled Member prescriptions were for generics, which means our Members are saving money, making it easier to adhere with prescribed medications. For more information on the drug formulary visit the Member portal or **healthoptions.org**.

Our pharmacy benefit manager, Express Scripts, offers a portal that gives Members a **high degree of control over their prescription ordering and prescription costs.**

Non-HSA Plans

Many group non-HSA plans offer our Chronic Illness Support Program (CISP) which removes certain cost barriers to help you secure the prescription drugs needed to manage your chronic illness. Qualified CISP medications have a CISP designation on the formulary. To view these medications, visit the Member portal or visit **healthoptions.org** to go to the formulary.

In a recent prescription drug utilization review, our team found that **90% of filled Member prescriptions were for generics.**

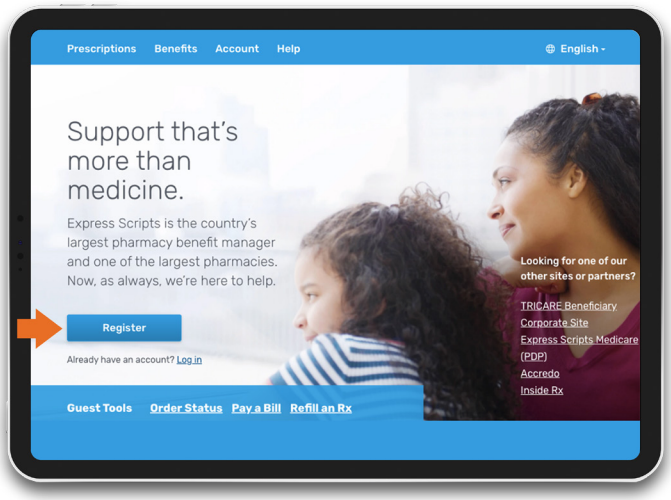
Pharmacy Management

Getting Started: Filling Prescriptions

Our goal is to help Members find the best prices for prescription medications and over-the-counter medicines prescribed by a provider. Health Options' pharmacy network gives you access to retail pharmacies throughout the country. Or, take advantage of **Express Scripts** Home Delivery, which is often a cost-saving option.

Benefits of home delivery:

- You can fill prescriptions for maintenance medications three months at a time through the ESI Extended Payment Program (EPP), which allows you to divide the cost over three payments.*
- For medications subject to a 30-day copay, you pay only two copays for a 90-day supply.*
- You can order CISP qualified medications as the CISP discount is only available through mail order.
- You can speak directly with an Express Scripts pharmacist when you have questions or concerns about your medications.



For more information go to **Express Scripts** to set up your account. It's as easy as following the **Register** steps as seen on the screen above.

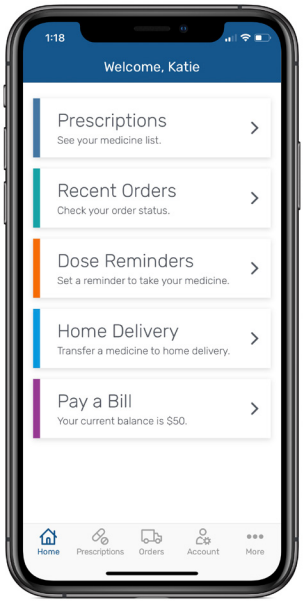
*Certain limitations apply.

Express Scripts Mobile App

STAY ON TRACK WHILE YOU ARE ON THE GO

The Express Scripts mobile app helps you manage your personal medication information—anytime, anywhere. You can order refills and renewals, check order status, transfer to home delivery, and price medications and more.

Just search for "Express Scripts" and download the app from your app store. Log in with your username and password. First-time visitors must register using their Member ID number or Social Security number (SSN). You can also use your device's touch ID authentication to log in, if available.



Pharmacy Management

Specialty Pharmacy

Health Options partners with Accredo to manage specialty medication needs.

- Accredo Home Delivery offers medications that treat chronic and complex conditions.
- The Accredo team is available to help you get the best possible financial coverage for specialty medications and help Members understand the available options.
- Accredo benefit specialists help Members navigate insurance coverage, approvals and eligibility.
- We know specialty medications are expensive. Many drug manufacturers and community organizations offer financial assistance programs. For more information, go to **accredo.com** or call (877) 895-9697.

Pharmacy Success Story

Our clinical pharmacist identified a 50-year-old Member who was not fulfilling his Metformin diabetes treatment because he could not afford the formulation he was prescribed. The pharmacist called the Member to discuss risks of not taking his diabetes medication. The pharmacist recommended a more affordable formulation and called the Member's prescriber to make the change. After this experience, the Member kept his prescriptions filled, improved his diabetes control, and saved more than $1,000 a year.

Medical and Care Management

Medical Management

Our Medical Management team includes a variety of healthcare professionals who work together to remove barriers, making it easier for Members to obtain medications and durable medical equipment. These specialists serve as a connection between Members and providers assisting with communication and education.

Care Management

Programs are available to aid Members through a broad spectrum of services. These include transitions of care such as hospital to home, disease management, chronic condition management, cancer care, maternity/post-partum care, and behavioral healthcare. Our Care Management team partners with a range of local agencies to assist with community supports and other wellbeing related issues.

MANAGING SERIOUS ILLNESS OR INJURY

When it comes to serious illness, our Nationally Accredited complex care management programs provide compassionate, personalized support for metastatic cancers, pediatric intensive care, and transplants. Assistance includes contacting providers, in-patient facilities and national transplant networks.

- Members with special care needs who are transitioning from a prior health insurance carrier will be paired with a Complex Care Manager to assist with transition to their new Health Options plan.
- Members identified with high health risks have access to complex care management resources.

HOSPITAL READMISSION PREVENTION PROGRAM

With a **31% year-over-year reduction** in readmission rate (2018 to 2019) and low single digits in 2020, we are working hard to help Members get well while reducing the costs associated with readmission to the hospital. In-house specialists coordinate with Care Management to assist Members at high risk of readmission. Examples include partnering with home health agencies, community agency care teams and other local agencies.

Medical and Care Management

Care Management (continued)

SITE OF CARE PROGRAM

Our Site of Care Program has saved millions of dollars in healthcare costs for our Members by offering the ability to transition certain medications and infusions to a preferred site of care, including a Member's own home. This program delivers a meaningful choice with **reduced out-of-pocket cost savings** and **increased quality of life**. An incentive program may be available for select medications and select sites of care.

SUBSTANCE USE DISORDER

Our Care Management team works closely with Members and dependents who are seeking treatment for substance use disorder. Our team provides **high quality, cost-effective, and convenient in-network program options**. This also includes transitional support after discharge from an inpatient behavioral health or substance use facility.

We're working every day to keep costs low and give you the healthcare benefits you **expect and deserve.**

Care Management Success Story

Recently, a Member diagnosed with cancer was referred to a Boston medical facility for treatment and a stem cell transplant. The Member had significant financial barriers, unreliable transportation, and was living in a home that contained mold. The Care Management team made a referral to the Maine Area Agencies on Aging which worked with our Member to arrange payment plans for a reliable car and a safe, new mobile home. The agency also helped the Member apply for monies from the Lymphoma Society, resulting in a $5,000 grant to help with medical expenses.

Member Services

Member Service Excellence

Our Maine-based, in-house customer service associates respond to Member calls and earn high satisfaction rates from our community. When you call our team, you can be assured that you will get the information you need. The Health Options Member Services team is led by two guiding principles:

PROMISES DELIVERED

When we make a promise to do something, we keep that promise. We always have your back. We are committed to Members' satisfaction every day. In recent post-call surveys with our Members, we earned **99% satisfaction for courtesy and respect, 98% for receipt of information needed and 98% for the speed of answer**.

WE DON'T ISSUE HOMEWORK

If a matter requires follow-up or if more information is needed, we will advocate for you to get the information, or be sure to connect you with the right people.

MEMBER SURVEY RESULTS:

99% satisfaction for courtesy and respect

98% satisfaction for receipt of information needed

98% satisfaction for speed of answer

"Community Health Options has impressed me with their responses to my emails. I have had other insurers and they never helped me the way you have so far. A big shout out to the email team and **the great job you provide on a daily basis!**"

Frequently Asked Questions (FAQs)

What is a PPO?

PPO stands for preferred provider organization. These plans provide coverage for both in-network and out-of-network services and providers.

- PPOs require you to select an in-network primary care provider (PCP) who has a contracted agreement with Health Options. In-network means we have a contract that states these providers will accept payment on the contracted dollar amount instead of their usual charges. Network providers cannot bill you for the difference between their charged rate and their contracted rate.
- PPOs **do not** require you to get a PCP referral for specialist care.*

Note: many specialists **do require referrals, even if our plans do not.*

What is an HSA?

HSA stands for a health savings account, which you are eligible for if you have a high deductible health plan. These accounts are a tax-free way for people covered by high deductible health plans to pay for qualified medical expenses. Medical payments made from an HSA are tax-free. Interest earned by an HSA is tax-free. HSAs have no "use it or lose it" restriction. If you don't use funds, they remain in your HSA each year, and your money continues to earn tax-free interest. Only certain plans qualify for HSAs. Consult a tax professional for more information.

What is a Primary Care Provider (PCP)?

A PCP can be an in-network physician, physician assistant or specialist in internal medicine, family practice, general practice, pediatrics, obstetrics or gynecology. PCPs can also be an advanced practice registered nurse or certified midwife licensed by the applicable state nursing board. Your PCP is a partner in your healthcare, advises you, and provides treatment on a range of health-related issues. He or she may assist you in your interactions with specialists.

What happens if my healthcare eligibility changes?

If you experience a qualifying event (such as a new baby), you may qualify for a Special Enrollment Period, which is time outside of the annual Open Enrollment when you or a family member can sign up for health insurance. The enrollment window is up to 60 days after the qualifying event and for some events up to 60 days prior. For more information, please check with your human resource department or group administrator.

Frequently Asked Questions (FAQs)

What life events could affect my health insurance coverage?

The following circumstances may trigger a need to change your coverage during Special Enrollment Period:

1. Loss of other qualifying coverage
2. Change in household size
3. Changes in primary place of living
4. Change in eligibility for financial help
5. Enrollment or plan error

Other Qualifying Changes:

1. Being determined ineligible for Medicaid or CHIP
2. Exceptional circumstances
3. Being a survivor of domestic violence or abuse or spousal abandonment
4. AmeriCorps service membership

What does in-network and out-of-network mean?

- **Our in-network** providers have signed a contract that states they will accept payment on our lower contracted dollar amount instead of their usual charges. Network providers cannot bill you for the difference between their charged rate and their contracted rate.
- **Out-of-network providers** have no contractual working relationship with Health Options. They can still provide care to Health Options Members, and we will allow them to bill us for covered services. Health Options will cover out-of-network services at the rate we would normally allow for any billed services. It is your responsibility to obtain prior approval for service provided by an out-of-network provider. The difference between the charged amount and the allowed amount can be billed to you, which is referred to as **balance billing**.

What is a Prescription Drug formulary?

The formulary is a list of covered prescription medicines that are safe and effective. All plans include a carefully created prescription drug formulary that emphasizes the prevention of chronic conditions and illnesses. Our formulary includes drug designations to indicate whether the drug is covered under the Chronic Illness Support Program (**CISP**), the Affordable Care Act (**ACA**), and other benefits offered on many Health Options plans. To view the prescription drug formulary visit **Drug Formulary**.

Note: Formulary changes can occur throughout the year, but the majority occur on or near January 1 and July 1. Members are notified when one of their medications is being removed from the formulary.

Frequently Asked Questions (FAQs)

What is cost-share?

The cost-share is your contribution to the cost of a service. This may include a deductible, co-insurance or a co-pay.

What do out-of-pocket costs include?

Out-of-pocket costs vary slightly according to your plan, but in general, co-pays, deductibles, and co-insurance are your out-of-pocket costs. Non-covered services are not included in out-of-pocket costs.

When do I have to pay for co-payments (co-pays)?

A co-payment is a fixed amount that you pay for a covered healthcare service, usually at the time you receive the service. Your co-pay is determined by your plan. Unless specified on your Schedule of Benefits, the deductible does not have to be met for the application of a co-payment. Co-payments do not count toward your deductible. Co-payments do count toward your out-of-pocket maximum.

What is an Explanation of Benefits?

An Explanation of Benefits (EOB) is a statement we will send you to explain what medical treatments and/or services were paid for on your behalf. EOBs are sent upon the completed processing of a medical claim. An EOB will explain the Health Options' payment and your financial responsibility pursuant to the terms of the policy. If you need assistance reading or interpreting your EOB, please contact Member Services at (855) 624-6463.

What is a deductible?

The deductible is the amount you pay for certain covered services before your plan pays benefits. **Payments for services that apply to the deductible are applied toward your deductible until the total is met.** If you have a family plan of three or more people, you may collectively meet a family deductible, at which point all individual deductibles are considered met.

How do I calculate my co-insurance?

The co-insurance amount you owe is based on a percentage of the allowed amount on a claim. You and the plan each pay a certain percentage, which together equals 100%. This normally applies once a deductible has been satisfied for many covered services. Please consult your plan's Schedule of Benefits for specific cost-sharing information.

Frequently Asked Questions (FAQs)

How are claims submitted?

Plan Providers will file claims directly with the Plan. Members may need to submit a claim for reimbursement for services from a non-plan provider.

Do I need prior approval/authorization for services?

Certain services and prescriptions require review and approval from our Utilization Management team or from our partner, Express Scripts Inc., prior to allowing coverage by the plan. If you receive care from an in-network provider, your provider is responsible for obtaining these authorizations. If you receive care from an out-of-network provider, it is your responsibility to obtain these authorizations. Call Member Services if you have any questions about our Prior Approval requirements.

More questions?

Call Member Services with your questions at (855) 624-6463, Monday through Friday, 8:00 a.m. to 6:00 p.m., or email the team at our **email form**.

Community Health Options is an innovative, Maine-based nonprofit health insurance partner **that has your back.**

At Health Options, Members talk to real people with real solutions. Our team of Maine-based Member Services Associates (MSAs) earn high marks for answering questions with courtesy, respect, and accuracy of information. Give them a call with your questions, (855) 624-6463, Monday – Friday, 8:00 a.m. to 6:00 p.m.

For more detailed information about our health plans or to review our Member Benefit Agreement and Schedule of Benefits, Provider Directory, Prescription Formulary or Privacy Notice, please visit our website at **healthoptions.org**. If you do not have access to a computer or internet services, please call (855) 624-6463.

COMMUNITY Health Options™

▲ BACK TO TABLE OF CONTENTS