Large Group Member Guide 2024

COMMUNITY Health Options®

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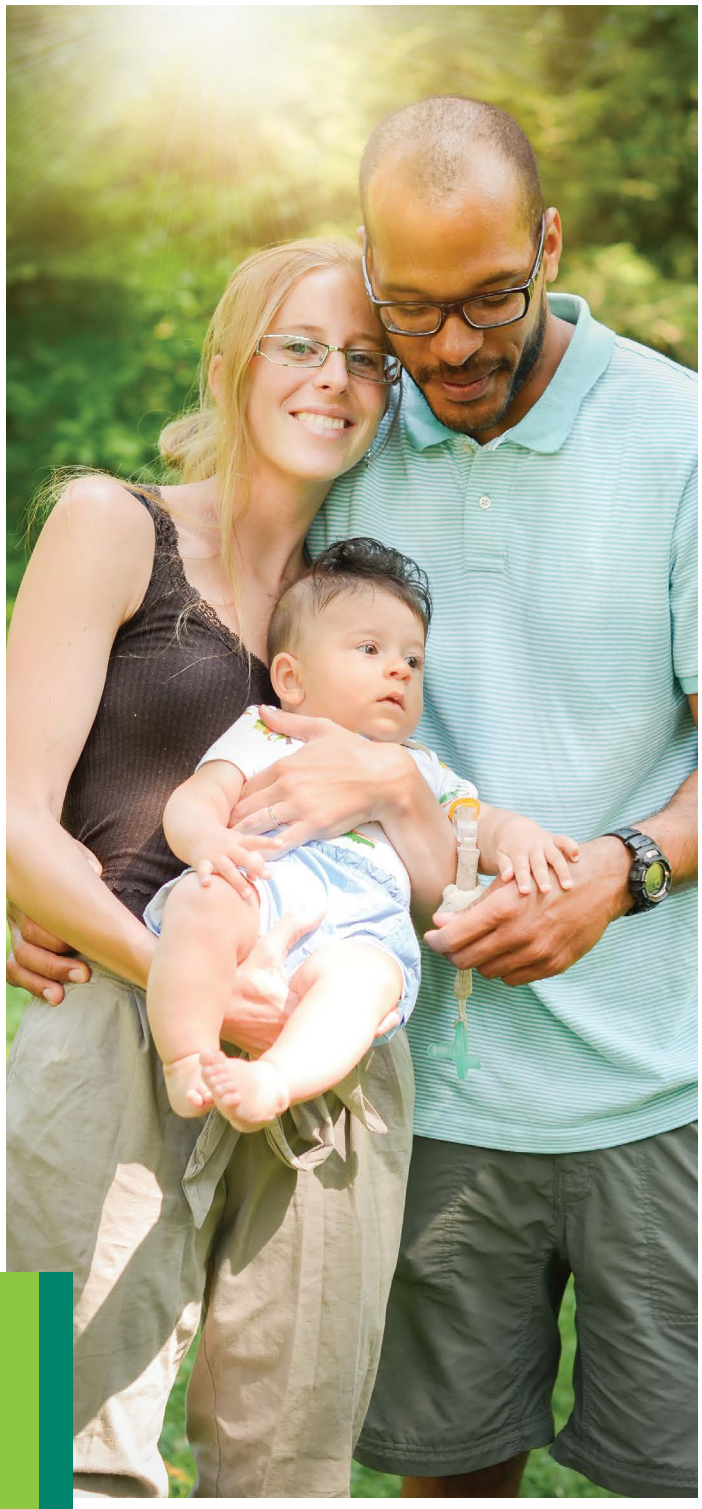
Community Health Options Overview

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

We work with a robust network of 48,000 providers including clinicians, hospitals and pharmacies in New England, with 100% of hospitals in Maine and most in New Hampshire.* Our plans include New England or national networks with a choice of PPOs, HMOs and Tiered HMO options for premium savings.

Customer service is where we excel. In recent surveys, our Maine-based team of Member support and service associates earned 100% satisfaction for courtesy and respect, 98% for receipt of information needed and 98% for the speed of answer.

Our team is ready to help you get the most from your plan benefits. It's healthcare insurance that feels different because it is.



We strive to keep costs low while providing the benefits you deserve.

*All Maine hospitals, except Togus VA Hospital.

Overview of 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:

NEW! Unlimited personalized health coaching on all plans available through the WellRight® platform for Members age 18 years and older with no deductible or cost for coaching on services such as nutrition, fitness, heart health and more.

NEW! Copay on all in-network acupuncturists on all non-HSA plans, with no deductible. Members can receive up to **$50 reimbursement** per visit for out-of-network visits.

NEW! Labs with a $25 copay at independent, non-hospital affiliated locations. HSA plans have a $25 copay after deductible.

Copays for all physical therapy, occupational therapy and speech therapy visits on non-HSA plans.

Tiered plans have lower copays or coinsurance, deductibles and maximum out-of-pocket expenses when using preferred providers versus standard providers.

Wellness platform and benefits All plans include access to the WellRight® digital wellness platform and mobile app at $0 cost to Members 18 years and older.

$5 copays on 30-day Tier 1 preferred generic medications on non-HSA plans.

Pharmacy benefit manager Express Scripts® supports filling prescriptions by mail for **home delivery** or through retail pharmacies.

Pediatric and adult vision coverage with one exam every 12-month calendar year. Pediatric exams are with a copay on many plans. Coverage also includes lenses, frames and contacts every 24-month calendar period.

Insulin with a copay not to exceed $35 for up to a 30-day supply for Members who require it.

Treatment for tobacco use at $0 out-of-pocket cost with enhanced benefits for over-the-counter nicotine replacement therapy (NRT) products, including nicotine patches, gum, lozenges, and certain FDA-approved medications listed on our drug formulary.

Urgent care telehealth visits with $0 cost share on non-HSA plans, and $0 after deductible for HSA plans via Amwell®.

First in-network primary care and first three behavioral healthcare visits annually per Member have no cost share on non-HSA plans.

Coverage for **chiropractic and osteopathic adjustments** on all plans.

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

Chronic Illness Support Program (CISP) offered on all non-HSA plans to reduce financial barriers for Members with chronic conditions (asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes and hypertension).

*For more detailed information about our health plans or to review our Provider Directory, Drug 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

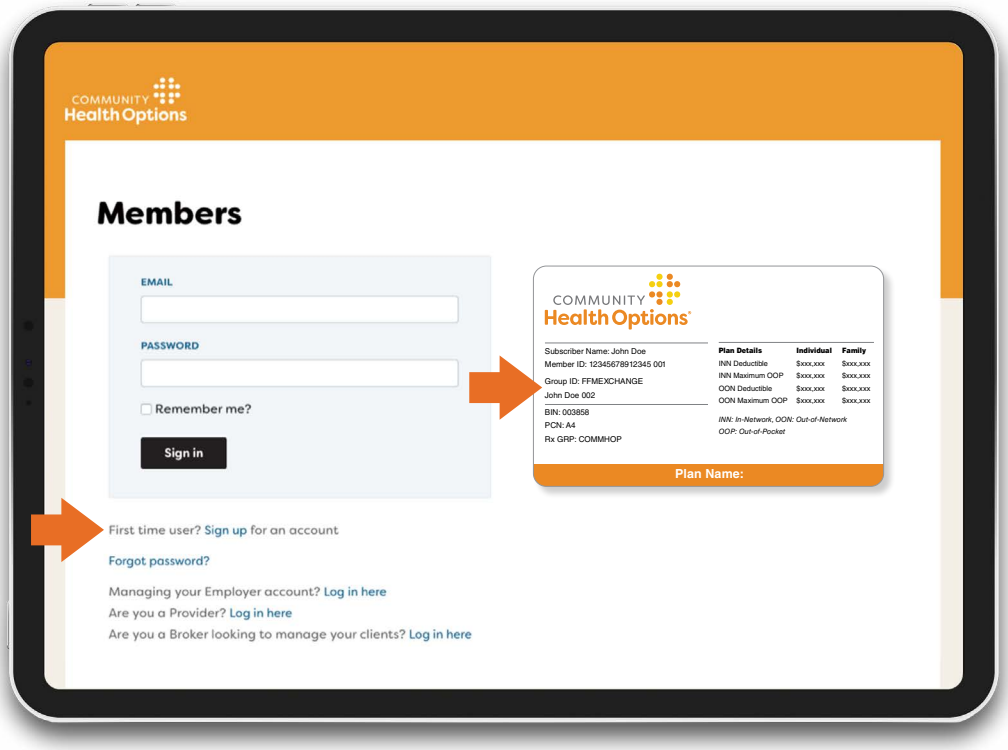
Upon enrollment, all Members receive a welcome packet that includes a Member ID card and instructions on setting up your online portal. The online Member portal provides access to plan benefits, claims, paperless delivery, primary care provider (PCP)/pediatrician (PED) selection and more. A protected health information (PHI) release form is also included. This gives Community Health Options permission 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:

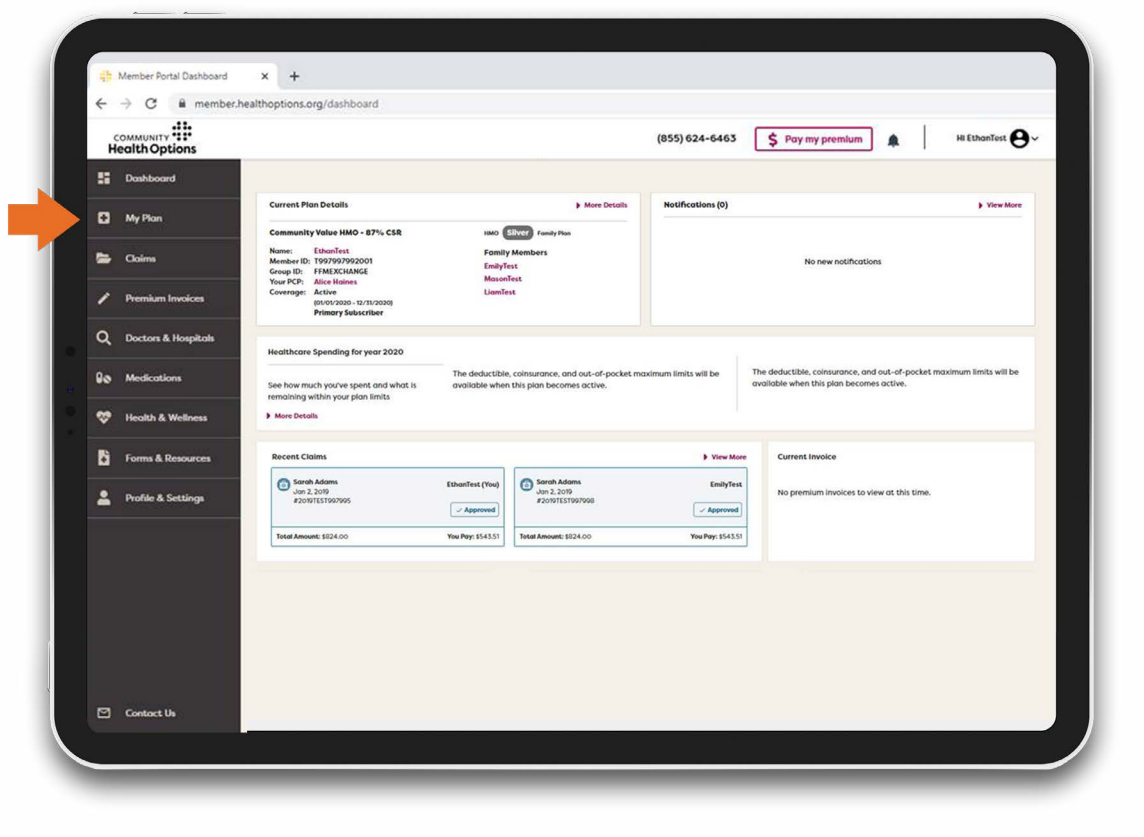
- Go to **healthoptions.org**.
- Click on **Sign In** at the far right upper corner of the screen.
- Select **Member Login**.
- Click on **First Time User? Sign up for an account**.
- At the next screen, enter your Member ID number, last name and date of birth.



Get to Know Your Member Portal

Once you set up your account, your **portal** displays your personal dashboard. From there, you can click on the menu on the left to navigate to the section you need.

Your home screen will also have quick links to items like your claims, deductible status and current notifications.



To view important plan documents, click on My Plan on the left side menu. Then, click Health plan information to access:

MEMBER BENEFIT AGREEMENT

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

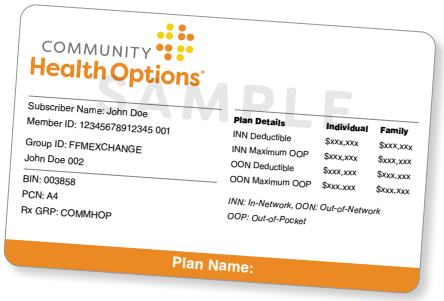
SUMMARY OF BENEFITS AND COVERAGE

An overview of your plan benefits, including your potential out-of-pocket costs.

SCHEDULE OF BENEFITS

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

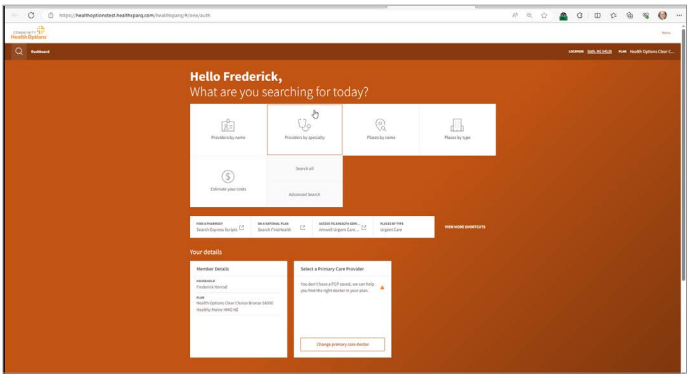
Get to Know Your Member Portal



More ways to use your portal to manage your benefits:

FIND A PROVIDER FOR YOURSELF OR A FAMILY MEMBER

- We have a variety of options to get you the healthcare that's right for you. In your Member portal, click on **Doctors and Hospitals** to open the provider search tool. This will begin a customized search experience based on your plan.



FIND ESTIMATES FOR SERVICES

- Use the cost estimator tool to understand and compare the costs of products and planned services. On your dashboard, click **Estimate My Costs** to learn more. This will present estimated costs and a customized cost share experience based on your plan.

STAY INFORMED

- A list of preventive healthcare benefits is available in the portal, as well as access to our FAQs, resource library and blog posts. In addition, Members have access to **Healthwise**, evidence-based, medically reviewed and trusted health information. Resources include articles, videos and interactive questionnaires.

Paperless delivery

Many communications are sent electronically to your Member portal, including Prior Approval letters and Explanation of Benefits. It's simple, secure and convenient. Plus, you can check your claims, see updates and more. **If you prefer to receive paper documentation, contact Member Services.**

Member Services is available Mon. to Fri., 8:00 a.m. to 6:00 p.m. at (855) 624-6463, or contact the team by clicking this **link**.

Navigating Your Network

NETWORK TYPES – What's the Difference?

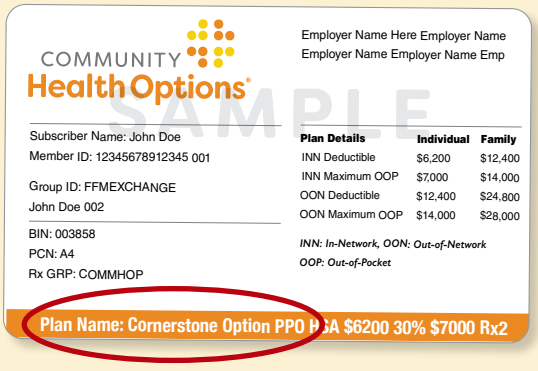
New England (NE) – Our **broad New England network** features more than 48,000 providers, including clinicians, hospitals and pharmacies in **Maine, New Hampshire, Vermont and Massachusetts**. All of our plans include the New England network.

Tiered New England (NE) – Community Health Options' tiered New England plans include access to all of the providers in our New England network and offer **reduced copays or coinsurance when you choose a preferred provider**. Our tiered plans include preferred providers throughout Maine and New England, including Centers of Excellence in Massachusetts.

National – For those who anticipate needing in-network care outside of our broad New England network, our **National plans include in-network access to First Health® providers across the country**.

1 Find your plan type

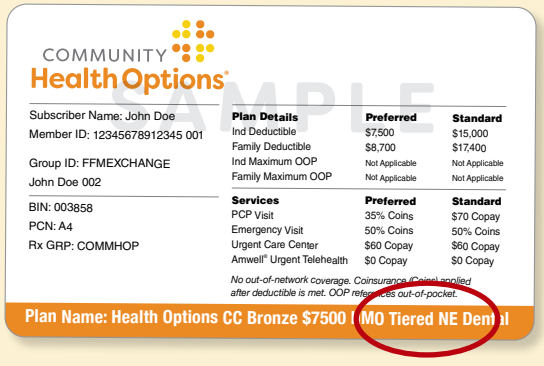
Look at your Member ID card to find your plan type, **HMO** or **PPO**. You can learn more about HMO and PPO plans on the following pages.



Plan name

2 Find your network type

Look at your Member ID card to find your network type, **New England (NE), Tiered NE** or **National**.



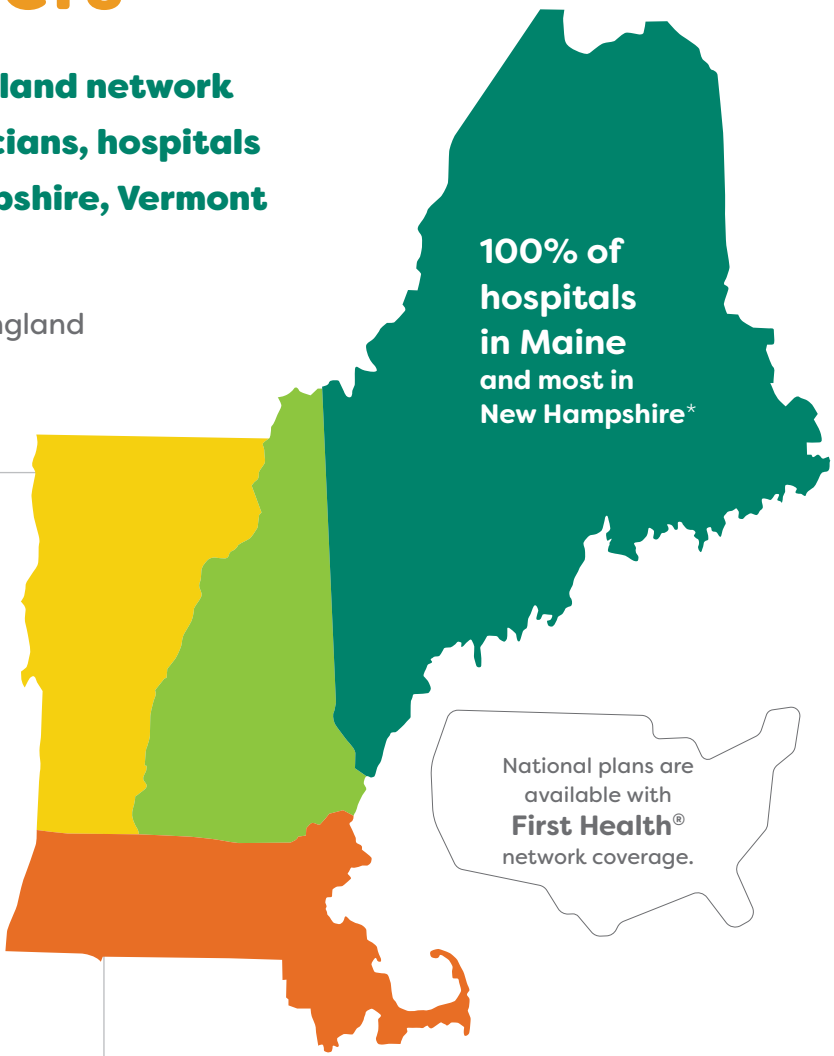
Network type

Find your plan and network type at the bottom of your card.

Network Providers

All plans feature our broad New England network of 48,000 providers, including clinicians, hospitals and pharmacies in Maine, New Hampshire, Vermont and Massachusetts.

National plans offer coverage beyond New England through the First Health® network.



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 Hospital
- Brigham and Women's Hospital
- Brigham and Women's Faulkner Hospital
- Boston Children's Hospital
- Newton-Wellesley Hospital
- North Shore Medical Center, Spaulding Hospital
- Springfield Hospital
- Dartmouth Hitchcock Hospital

*All Maine hospitals, except Togus VA Hospital.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service Type	Within New England	Outside of New England	Out-of-Country
Medical, Behavioral and Substance Use Disorder	All Community Health Options plans include an expansive network of providers throughout ME, NH, VT and MA as well as all Centers of Excellence in MA.	Access to providers throughout New England, as well as national providers through the First Health® network.	All plans include access to care for emergent conditions outside the U.S.
Pharmacy	The Express Scripts® National Pharmacy Network includes most national and local pharmacies.		

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

Network Providers–HMO

All HMO plans have in-network access to our broad New England network.

Our tiered HMO plans offer an even more affordable option that includes the same New England network, but with reduced cost sharing (copays, coinsurance, deductible and out-of-pocket maximum) when Members choose a preferred tier provider. **Our tiered plans include preferred providers in Maine, New Hampshire, Vermont and Massachusetts.**

Large Group tiered HMO plans do not include out-of-network coverage except for access to care for emergent conditions within and outside the U.S.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	HMO Tiered NE
Medical, Behavioral and Substance Use Disorder	Offers in-network access to Community Health Options' broad New England network with **reduced copays or coinsurance for preferred tier providers**.* A lower deductible and out-of-pocket maximum applies for preferred providers. Standard providers have a standard copay, coinsurance, deductible and out-of-pocket maximum. ***All preferred provider cost sharing is applied to both the preferred and standard out-of-pocket maximum.*** **There is no out-of-network coverage with the exception of emergency services listed below.*
Telehealth	If a provider offers telehealth services, **routine in-network and out-of-network rates will apply**. In-network telehealth through Amwell® for behavioral health and urgent care is available on all plans.
Emergency Services	All Large Group plans include access to care for emergent conditions within and outside the U.S.
Pharmacy	The Express Scripts® National Pharmacy Network **includes most national and local pharmacies**.

Network Providers–PPO

All PPO plans have in-network access to our broad New England network, and out-of-network coverage is available with higher cost sharing. Our PPO national plans include access to First Health® providers across the country.

With a PPO plan, Members have coverage for out-of-network services and providers, but will pay more out-of-pocket.*

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	PPO NE	PPO National
Medical, Behavioral and Substance Use Disorder	**Community Health Options' broad New England network** includes providers across **ME & NH,** as well as a limited number of key providers in **MA & VT**. *For services outside of ME, NH, MA and VT, out-of-network coverage is available with higher cost sharing.**	Includes Community Health Options' broad New England network, as well as **in-network national coverage through the First Health® network.** *Out-of-network coverage is available with higher cost sharing.**
	**With the exception of emergency services at the emergency department, Members may be subject to balance billing if services are rendered by an out-of-network provider. Members are responsible for ensuring Prior Approval requirements are met for out-of-network providers when required.*	
Telehealth	If a provider offers telehealth services, **routine in-network and out-of-network rates will apply.** In-network telehealth through Amwell® for behavioral health and urgent care is available on all plans.	
Emergency Services	All plans include access to care for emergent conditions within and outside the U.S.	
Pharmacy	The Express Scripts® National Pharmacy Network **includes most national and local pharmacies**.	

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 members of your family. To make sure you are finding a provider who fits your needs:

- Ask the PCP/PED about office hours and whom to contact after hours.
- If you are on a tiered plan, check to be sure the PCP/PED has a tiered designation.
- 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.
- Preventive care visits with in-network PCP/PED providers are available at zero cost share. Services covered are based on the recommendations listed at **healthcare.gov**. Note: Tests and additional services provided during the visit may be subject to routine cost sharing.

Network Providers

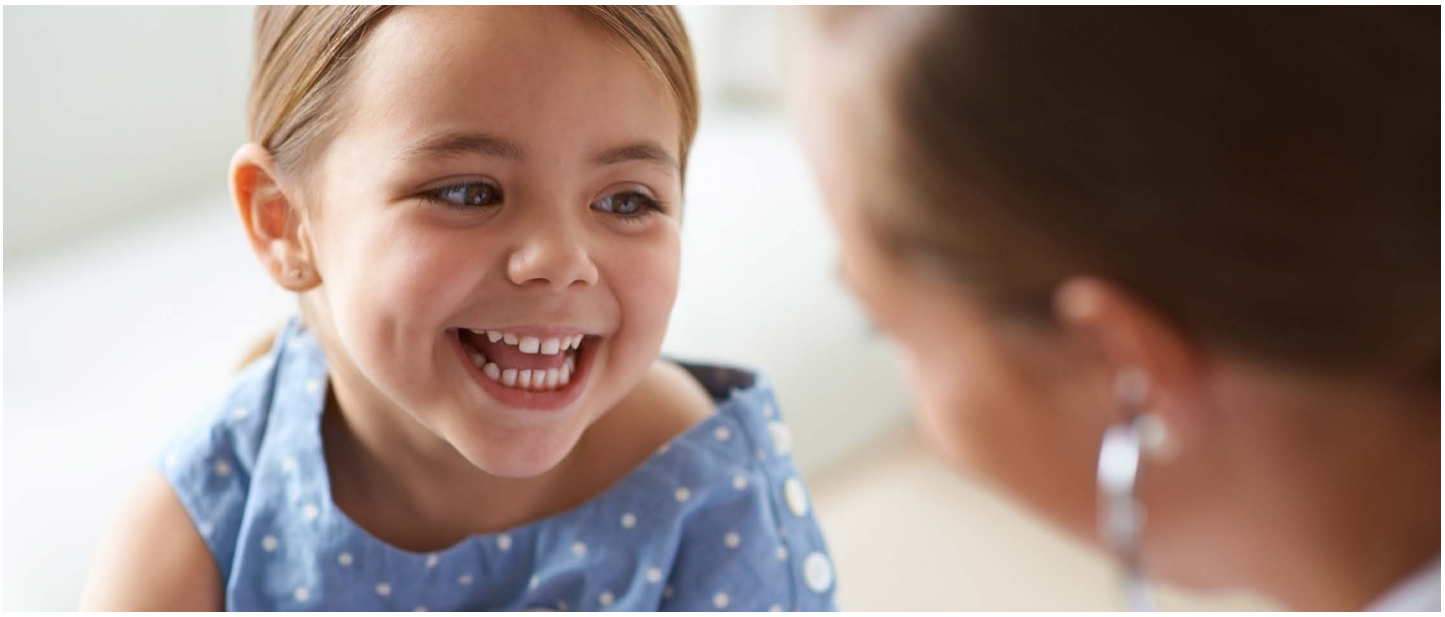
More questions about where to go for care?

Use this chart to make the best choices based on your healthcare needs—and **save money** in the process.

WHERE TO GO FOR CARE

Primary 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 Community Health Options coverage began.* **Note:** If you are on a tiered plan, make sure you select a preferred provider for reduced costs.	**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 a hospital emergency department.)



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

Urgent Care

Healthcare Service	When & Why to Choose This Option	Typical Expense
Amwell® Urgent Care Telehealth *Visits online or over the phone with a clinically licensed urgent care provider.*	**Log in to Amwell® Urgent Care when you need quick care for non-life-threatening conditions.** • Headaches • Minor burns • Minor infections • Cold, flu, strep symptoms • Respiratory infections	$0 **No cost share** for all non-HSA plans; and $0 after deductible for HSA plans.
Urgent Care *These are stand-alone, walk-in clinics.* *Click here for a list of in-network urgent care locations.* **Note:** If you are on a tiered plan, make sure you select a preferred urgent care location for reduced costs.	**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	$ $ $

Preventive Care

Community 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. Unlike other carriers, Community Health Options does not require you to wait 366 calendar days between visits to see your provider for annual preventive wellness care and checkups. These annual visits reset based on the date your coverage begins, not the date of your last appointment. While it is best to schedule your yearly preventive services approximately 12 months apart to get maximum benefit, you have some flexibility with appointment dates and peace of mind knowing your care is on your schedule. Annual wellness visits based on your plan year include preventive wellness visits, mammograms, adolescent hearing screenings, low-dose CT scans for lung cancer screening, labs and immunizations.

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 adult and pediatric preventive care and are administered by in-network providers are covered with no cost share.

Preventing influenza is important to Community 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.

There is no cost share for **COVID-19** vaccinations or provider-administered COVID-19 testing/screening.

Preventive screenings often 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 Screening Colonoscopies with no cost share for Members age 45 and older. Preventive health screening colonoscopies have no deductible, coinsurance or copay.

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 your health.

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 sharing.

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 sharing.

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 sharing.

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?
- Is there an in-network option for this service?

If you are in a tiered network plan and additional services or tests are recommended, be sure to check for an in-network provider. 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 **contact** the team.

Preventive Care

Commonly Asked Preventive Services Questions

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

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

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

Which immunizations are covered as a preventive service?

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

- Most childhood (age 18 or younger) vaccinations, including HPV for boys and girls, are covered. A list of **child and adolescent routine immunizations** (age 18 or younger) may be found **here**.
- A list 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 sharing. Screening tests, such as some cholesterol and blood sugar tests, are covered with no cost share based on age and certain risk factors and provided the blood test is not monitoring a diagnosed condition. Lab tests included as preventive services can be found at **healthcare.gov**, or by visiting one of the resources listed below:

- View the list of Preventive Care Benefits for women by clicking **here**.
- Visit the Preventive Care Benefits for children from healthcare.gov by clicking **here**.
- Visit the Adult Preventive Services benefits by clicking **here**.

**New guidelines may be published. The timing of no-cost coverage is applied to a future date. For example, a recommended service release date in March 2023 may not be covered as a preventive service until 2025.*

Wellness Benefits

Set up your Member portal for easy access to these resources and services, as well as other important plan details and documents.

Primary Care

There is no cost share for your first primary care visit during a plan year in non-HSA plans. Tests and services provided during that visit may be subject to standard cost share. Unlike other carriers, Community Health Options does not require you to wait 366 calendar days between visits to see a provider for annual preventive wellness care and checkups. For more information about preventive wellness, please refer to the Preventive Care section of this guide.

Telehealth for Provider Visits

A provider visit can be just a click away. Community Health Options removes obstacles that may keep Members from accessing necessary healthcare. If a provider offers the service, you can use video-conferencing telehealth visits via the internet. The visit will have the same plan coverage as in-network or out-of-network provider office visits. You can also receive telehealth services 24/7 for urgent care and schedule online behavioral healthcare through our partnership with Amwell®. **There is no cost share for Amwell urgent care telehealth visits on non-HSA plans.**

Behavioral Health

The first three in-network, outpatient behavioral health visits for you or your dependents have no cost share on non-HSA plans for in-person or online/telephonic visits. Outpatient behavioral health services are provided at preferred cost sharing on tiered HMO plans. We will even cover a medical visit and a behavioral health visit on the same day, and we can facilitate same-day referrals. Amwell also offers **telehealth psychiatry and counseling/therapy services**.

Amwell® Telehealth

We offer telehealth for urgent care, psychiatry and **counseling/therapy** through our partnership with Amwell. This option makes it easy and fast for Members and their dependents to access care. One-time and continued behavioral healthcare visits can be easily managed online, scheduling seven days a week. Our urgent care telehealth is available 24/7, providing access to treatment whenever you need it. Additionally, there is **no cost share for Amwell urgent care telehealth visits on non-HSA plans and $0 after deductible for HSA plans**.

Chiropractic and Osteopathic Manipulative Coverage

All plans include coverage for chiropractic and osteopathic adjustments. Many non-HSA plans offer coverage with a copay, and Prior Approval is required for some services, (e.g., advanced imaging such as MRIs) ordered by a provider. Detailed information is available within your plan documents.

Wellness Benefits

Acupuncture

All plans include the acupuncture benefit. Many non-HSA plans have visits with a copay for in-network acupuncturists. In addition, you are not required to meet a deductible before accessing acupuncture benefits and are eligible for reimbursement of up to $50 per visit for out-of-network visits.

Vision

All group plans offer adult and pediatric vision coverage, including one routine eye exam per 12-calendar-month period with deductible and coinsurance on adult exams. On many plans, pediatric visits are covered with a copay.

Oral Health

Large Groups have the option to contract with our partner, New England Delta Dental (NEDD) to offer both pediatric and adult coverage. A special, low dental deductible applies and covered out-of-pocket dental expenses are applied to medical out-of-pocket expenses. Detailed information is available within your plan documents.

Wellness Programs & Tools

Our programs and tools are designed to help you reach your wellness goals. Whether you are already on your path to better health or you're just getting started, we'll be there every step of the way.

Health Education

Our partners at Healthwise® provide evidence-based, medically reviewed health information that you can trust including a symptom checker, decision support tools, and thousands of articles and videos with up-to-date health information. Use this education platform to gain knowledge and stay informed on topics that matter. You can access Healthwise materials in your Member portal.

Digital Wellness Platform and App

We partner with WellRight® to provide a digital wellness engagement platform and mobile app at no cost to Members 18 years and older. The platform is rich with wellness challenges, a sense of community and gamification—including daily text nudges, opportunities to earn rewards, and health education geared toward driving positive habit formation and behavior change. The holistic and personalized approach guarantees a path toward better health. Members with this program can access their account through the health and wellness tab in the Member portal, download the WellRight app, or log on to **healthoptions.wellright.com**. Please note that if you download the mobile app to set up your account, you will need to enter the company code "healthoptions" to begin your personalized experience.

Unlimited Personalized Health Coaching

All plans offer unlimited personalized health coaching to Members age 18 years and older with **no deductible** and **no cost** through the WellRight platform. Trained health coaches can meet over the telephone, through text, video chat or email and can assist with the following:

• Personalized Nutrition • Physical Activity • Weight Management • Financial Fitness • Prenatal Wellness
• Heart Health • Tobacco Treatment • Stress Management • And more!

Tobacco Treatment Support

Our Tobacco Cessation Program offers an enhanced benefit for over-the-counter nicotine replacement therapy products, including nicotine patches, gum, lozenges, and certain FDA-approved medications listed on our drug formulary, and it is available at $0 out-of-pocket. Our care managers are available to support you along your journey to becoming tobacco free. Call Member Services at (855) 624-6463 to get started.

Care Management

Our care managers are specially trained to help you with the medical services you need and to assist you with saving money on prescribed medications. 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/postpartum care, and behavioral healthcare. Our Care Management team partners with a range of local agencies to offer community support.

Chronic Illness Support Program

All non-HSA plans include our popular Chronic Illness Support Program (CISP), designed to improve the health and well-being of Members with asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes and hypertension.*

Members who manage their conditions through in-network office visits can save on routine care. Additionally, Members can save on CISP designated medications when ordering through the Express Scripts (ESI) mail order pharmacy.

BENEFITS INCLUDE

- **Select Tier 1 Generic Medications** at $0 with ESI mail order.
- **Preferred Tier 2 and 3 Medications** at 50% cost share reduction with ESI mail order, and deductible is waived.
- **Select Medical Services** at $0 when performed by a network provider (see chart below).

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 mail order 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

**Not available on catastrophic plans.*

Pharmacy Management

Our in-house pharmacists support the development of a competitive and cost-effective prescription drug formulary in partnership with our Pharmacy Benefit Manager (PBM), Express Scripts®. They have designed an easy-to-use formulary with five tiers based on cost. For more information on copays by tier, 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

Prescription Programs

Saving our Members money while covering the medications they need is our top priority. Therefore, through our **Price Assure** program, Members automatically save on generic medications when they take their prescriptions to in-network pharmacies that also accept **GoodRx**®. And through our new **Medication Synchronization Program**, our Pharmacy team works directly with Members with three or more chronic prescriptions to coordinate their refills to be picked up at the same time—eliminating multiple trips to the pharmacy. Additionally, through our **ScriptSaver** program, our Pharmacy team works with Members, their providers, and pharmacy to find cost-saving opportunities.

Special Insulin Provision

Members requiring insulin will have a cost share not to exceed **$35 for up to a 30-day supply on all plans**.

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 when ACA preventive care requirements are met. This means there is no cost share (deductible, copayment, or coinsurance). 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.

Low Copay Preferred Generic Medications (Tier 1)

All non-HSA plans offer Tier 1 medications at a **$5 copay for 30 days**.* Ninety days of medication is available for a **$10 copay** if obtained through mail order with Express Scripts. **HSA Plus** plans offer select Tier 1 medications with no deductible, but out-of-pocket costs apply.

HSA Plus Enhanced Preventive Drug Coverage

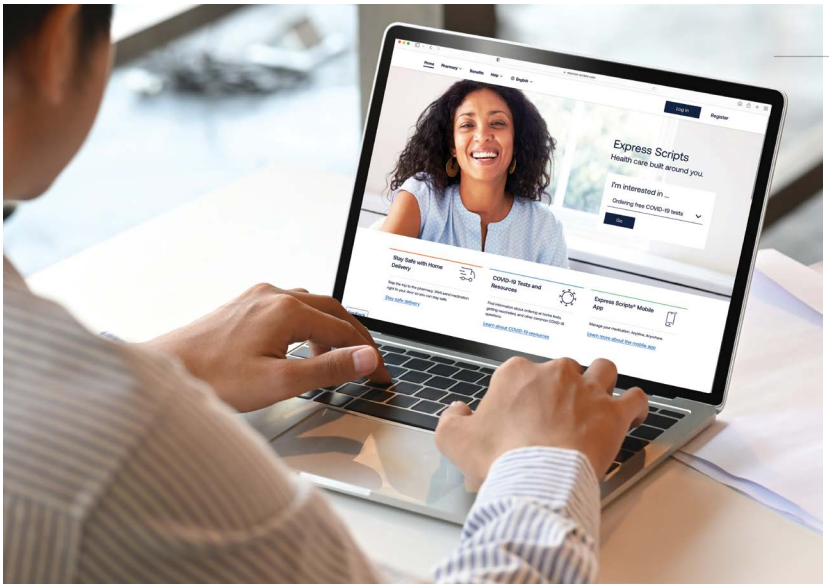
HSA Plus plans include a carefully curated list of medications to help prevent the development of and reduce the risk of complications due to chronic conditions and illnesses. These prescription drugs are identified on the formulary with an H.S.A notation. These drugs indicated as H.S.A. bypass the deductible and require Members to pay only the applicable coinsurance or copayment amounts. To view the H.S.A.-designated drugs, review the formulary in your Member portal or at **healthoptions.org**.

**Not available on catastrophic plans.*

Pharmacy Management

Pharmacy Benefit Manager

Our pharmacy benefit manager, Express Scripts®, offers a portal that gives Members a high degree of control over their prescription ordering and prescription costs with auto-generated comparisons and suggestions for lower cost medication options. **In a recent prescription drug utilization review, our team found that 88% of filled Member prescriptions were for generics,** which means our Members are saving money, making it easier to adhere to prescribed medications. This means healthier Members. For more information on the drug formulary visit **healthoptions.org**.



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

In a recent prescription drug utilization review, our team found that **88% of filled Member prescriptions were for generics**, helping our Members save money.

Pharmacy Management

Getting Started: Filling Prescriptions

We want Members to benefit from the best prices for prescription medications and over-the-counter medicines prescribed by a provider. Community Health Options' pharmacy network gives you access to retail pharmacies throughout the country; or, take advantage of Express Scripts® mail order, which is often a cost saving option.

Benefits of mail orders:

- You can fill most 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 Chronic Illness Support Program qualified medications through mail order at the CISP discount.
- 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 clicking on the **Register** button and following the prompts.

*Certain limitations apply.

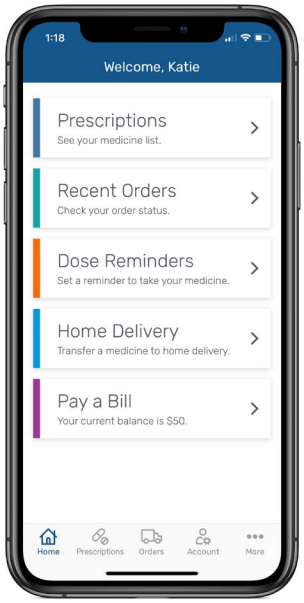
ACTIVATE YOUR EXPRESS SCRIPTS ONLINE PORTAL

- Express Scripts, our pharmacy benefit manager, 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.**

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 mail order, 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

Community Health Options partners with Accredo® to manage specialty medication needs.

- Accredo mail order 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** or call (877) 895-9697.

Pharmacy Success Story

When severe winter storms caused shipping delays, a Member with multiple sclerosis was unable to get her medication. She called Member Services, terrified of a relapse. Our pharmacist found a local supply for $250, but reduced the Member's cost to $0 with a manufacturer's coupon.

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 and assist with communication and education.

Care Management

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 Community Health Options plan.
- Members identified with high health risks have access to complex care management resources.

HOSPITAL READMISSION PREVENTION PROGRAM

With a **53% reduction** in readmission rate (2018–2022), we are working hard to help Members get well while reducing 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 voluntary **Site of Care Program** has saved millions of dollars in healthcare costs for our Members by offering the ability to transition certain medications that need to be delivered intravenously (IV) 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 costs** and **increased quality of life**. In addition to these savings, Members will be offered a monetary incentive payment for select medications when receiving infusions from a preferred Site of Care provider.

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 includes transitional support after discharge from an inpatient behavioral health or substance use facility.

We work every day to keep costs low and give Members the healthcare benefits they **expect and deserve.**

Care Management Success Story

A care manager had been working with a Member whose son was struggling with depression, which at one point required hospitalization. In 2022, the woman's son was among many patients in Maine waitlisted for care. The care manager was able to find a mental health provider for the woman's son and his condition stabilized with regular support and treatment. "I will never forget how my care manager was able to help me and my child. Our lives have changed because of their efforts and guidance. It's scary and intimidating to seek help for yourself, and an even more desperate and troublesome situation when your child is in need. My care manager was amazing in her ability to recognize and point out what we needed and how to navigate all of it," said the boy's mother.

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 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 **100% 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:

100%	satisfaction for courtesy and respect
98%	satisfaction for receipt of information needed
98%	satisfaction for speed of answer

"The representative I spoke with was the best! She explained the procedure and made me feel like I was family. After my surgery, I called back to ask some questions and spoke with another representative, who was just as great! She educated me on things that would help me save money on prescriptions. After helping me, she transferred me to Express Scripts, where the representative was also awesome. How can one company hire so many wonderful people? What a life changing experience!"

Frequently Asked Questions (FAQs)

What is a Preferred Provider Organization (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 Community 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. However, many specialists DO require referrals, even if our plans do not.
- If you choose out-of-network services and providers, these costs are applied to a separate deductible and out-of-pocket maximum than your in-network services and providers. Costs are paid at the "usual and customary" rate. If the costs exceed this amount, you may be billed for the difference.

What is a Health Maintenance Organization (HMO)?

HMO plans include Community Health Options' broad provider network. However, they do not include out-of-network coverage except for emergent conditions in the emergency department. HMOs can be less expensive as they do not include out-of-network coverage. Primary care providers will generally assist in managing your overall care on HMO plans.

What is a Health Savings Account (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 tiered HMO plan?

Tiered HMO plans provide access to Community Health Options' broad New England network. Providers and facilities that meet or exceed our quality, price and efficiency standards are "preferred," and other in-network providers are "standard." The preferred tier offers high quality and lower cost share to you including lower copays, coinsurance, deductible and out-of-pocket maximum. Tiered plan Members can continue receiving care from a standard tier provider with a standard cost sharing. These plans do not have out-of-network coverage, except for emergency services within the U.S.

Frequently Asked Questions (FAQs)

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 moving or having 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.

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

Termination of your coverage under a group plan may be a qualifying life event for a SEP during which you may purchase an individual health plan. The enrollment window is up to 60 days after the qualifying event, and for some events, up to 60 days prior. You can also enroll in an individual health plan during Open Enrollment, which generally runs from November 1 to December 15. Exact dates for the current year can be found at **CoverME.gov**.

To avoid a gap in coverage, consider applying for individual coverage prior to termination of group coverage. All Maine residents not eligible for Medicare may purchase any individual health plan.

Frequently Asked Questions (FAQs)

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

- **Our in-network providers** have signed a contract with us to accept payment on our lower contracted dollar amount instead of their usual charges. In-network providers cannot bill you for the difference between their charged rate and their contracted rate.
- **Our out-of-network providers** have no contractual working relationship with Community Health Options. However, you may still receive care from these out-of-network providers if you have a PPO plan. If you see a doctor out-of-network, we will cover the visit at the out-of-network rate. It is the Member's responsibility to obtain Prior Approval for services provided by an out-of-network provider. In certain circumstances, the difference between the amount the provider bills you and the amount your benefits pay is defined as **balance billing**. This differential amount would be at your cost and does not apply to your maximum out-of-pocket expense per plan guidelines. As a reminder, HMO plans do not offer out-of-network benefits.
- All Large Group plans offer **coverage for emergent conditions** in the emergency department when you travel **out of the country**. If you plan to travel outside the U.S., including Canada, please check your plan benefits and consider supplemental travel insurance.

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 Community Health Options plans. To download our prescription Drug Formulary, **click here**.

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.

What are covered vs. non-covered services?

Covered benefits are health services that your insurance policy pays for. You may be required to pay copays, coinsurance or deductibles. **Non-covered benefits or exclusions are those that an insurance plan does not pay for.** For more information about covered services, please read your Member Benefit Agreement.

What do out-of-pocket costs include?

Out-of-pocket costs, also known as cost sharing, vary slightly according to your plan but in general, co pays, deductibles, and coinsurance are your out-of-pocket costs. Non-covered services are not included in out-of-pocket costs.

Frequently Asked Questions (FAQs)

What is a copayment (copay)?

A copayment is a fixed amount that you pay for a covered healthcare service, usually at the time you receive the service. Your copay 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 copayment. Copayments do not count toward your deductible or out-of-pocket maximum unless otherwise stated on your Schedule of Benefits.

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 Community 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. You can find more information about your deductibles in the Member portal.

How do I calculate my coinsurance?

The coinsurance 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.

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 for services?

Certain services and prescriptions require review and approval from our Utilization Management team or from our partner, Express Scripts® prior to allowing coverage by the plan. If you receive care from an in-network provider, your provider is responsible for obtaining these approvals. If you receive care from an out-of-network provider, it is your responsibility to obtain these approvals. More information about Prior Approvals for medical, behavioral health, and prescription benefits is available **here**, or contact our Member Services team for assistance.

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

At Community Health Options, Members talk to real people with real solutions. Our team of Maine-based Member Services Associates earns high marks for answering questions with courtesy, respect and accuracy of information.

Give them a call with your questions at (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 Provider Directory, Drug 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®