



A Maine-based nonprofit
health insurance partner
that has your back

Large Group Member Guide 2023

Table of Contents

► CLICK ON ANY TITLE TO JUMP TO THAT SECTION

- 3** [Community Health Options Overview](#)
- 4** [Overview of Group Benefits](#)
- 5** [Finding Important Information About Your Plan](#)
- 6** [Get to Know Your Dashboard](#)
- 8** [Network Providers](#)
- 12** [Preventive Care](#)
- 15** [Wellness Benefits](#)
- 18** [Chronic Illness Support Program \(CISP\)](#)
- 19** [Pharmacy Management](#)
- 23** [Medical and Care Management](#)
- 25** [Member Services](#)
- 26** [Frequently Asked Questions \(FAQs\)](#)
- 30** [Contact Information](#)

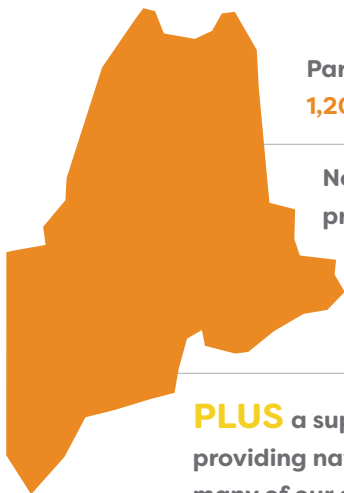
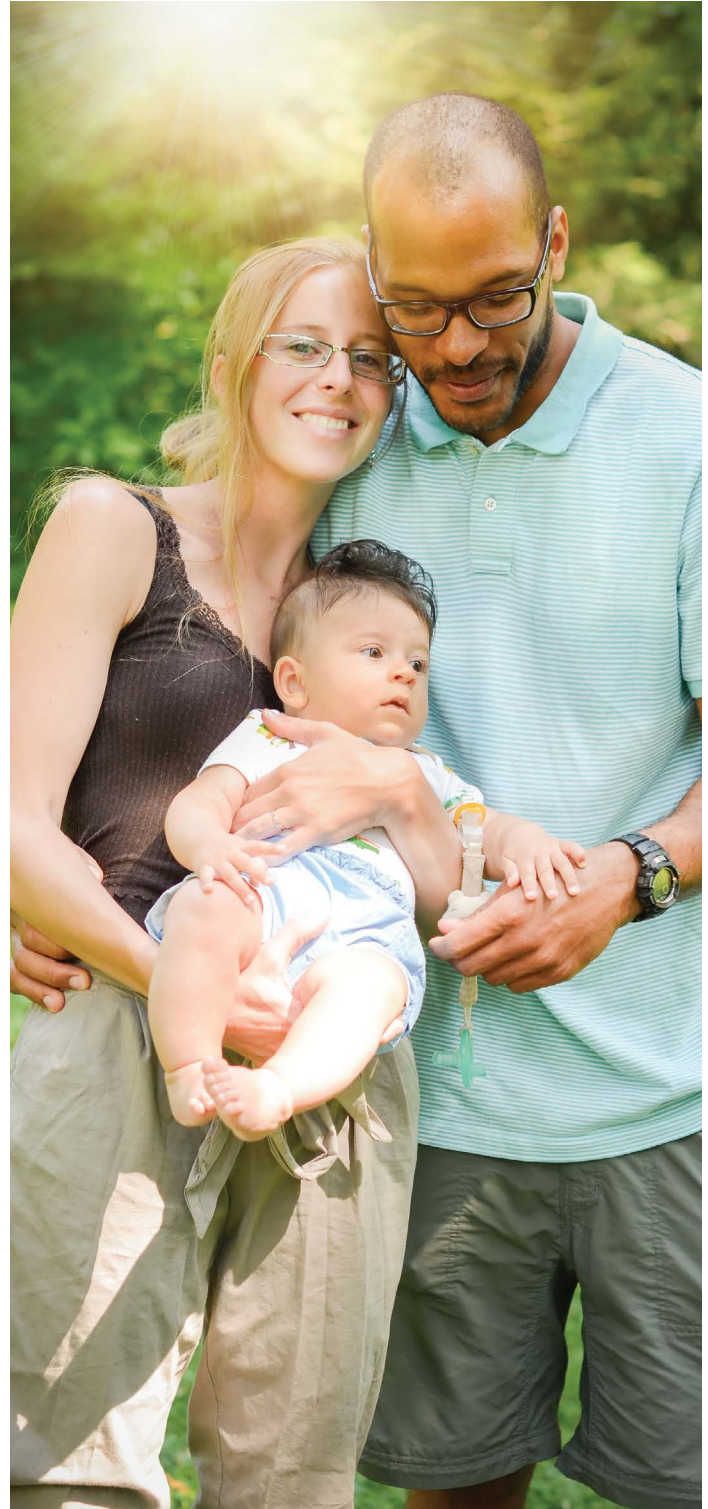


Community Health Options Overview



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 1,200 businesses, a number that continues to grow. We have a robust network of 48,000 providers, including clinicians, hospitals, and pharmacies in New England, with a supplemental network providing national coverage within most of 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. Our sophisticated in-house systems were built from the ground up and are managed here in Maine by Maine-based employee experts.



Partner with
1,200 businesses

Network of **48,000**
providers, including clinicians,
hospitals, and pharmacies
in New England

PLUS a supplemental network
providing national coverage within
many of 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:



NEW! Wellness platform and benefits

Health Options partners with WellRight® on all plans to provide a digital wellness platform and mobile app at no cost to individuals and their families.



Co-pay of \$5 or less for 30-day Tier 1

preferred generic prescriptions on select Large Group plans.



For Members ages 45 and older, **preventive health screening colonoscopies have no deductible, co-insurance or co-pay.**



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 at **no out-of-pocket cost** from in-network providers.



Pediatric and adult vision coverage including one exam every 12-month calendar year. Also includes coverage for lenses/frames/contacts every 24-month calendar period.



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



Tobacco cessation support with 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 at a **\$0 out-of-pocket cost.**



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 in non-HSA 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) is available 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](https://www.healthoptions.org). If you do not have access to a computer or internet services, please call (855) 624-6463. ©2023 Community Health Options. All rights reserved.



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 their 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).

Members

EMAIL
[Input Field]

PASSWORD
[Input Field]

Remember me?

Sign in

First time user? [Sign up for an account](#)

[Forgot password?](#)

Managing your Employer account? [Log in here](#)

Are you a Provider? [Log in here](#)

Are you a Broker looking to manage your clients? [Log in here](#)

COMMUNITY Health Options

Subscriber Name: John Doe
Member ID: 12345678912345 001
Group ID: FFMEXCHANGE
John Doe 002
BIN: 003858
PCN: A4
Rx GRP: COMMHOP

Employer Name Here Employer Name
Employer Name Employer Name Emp

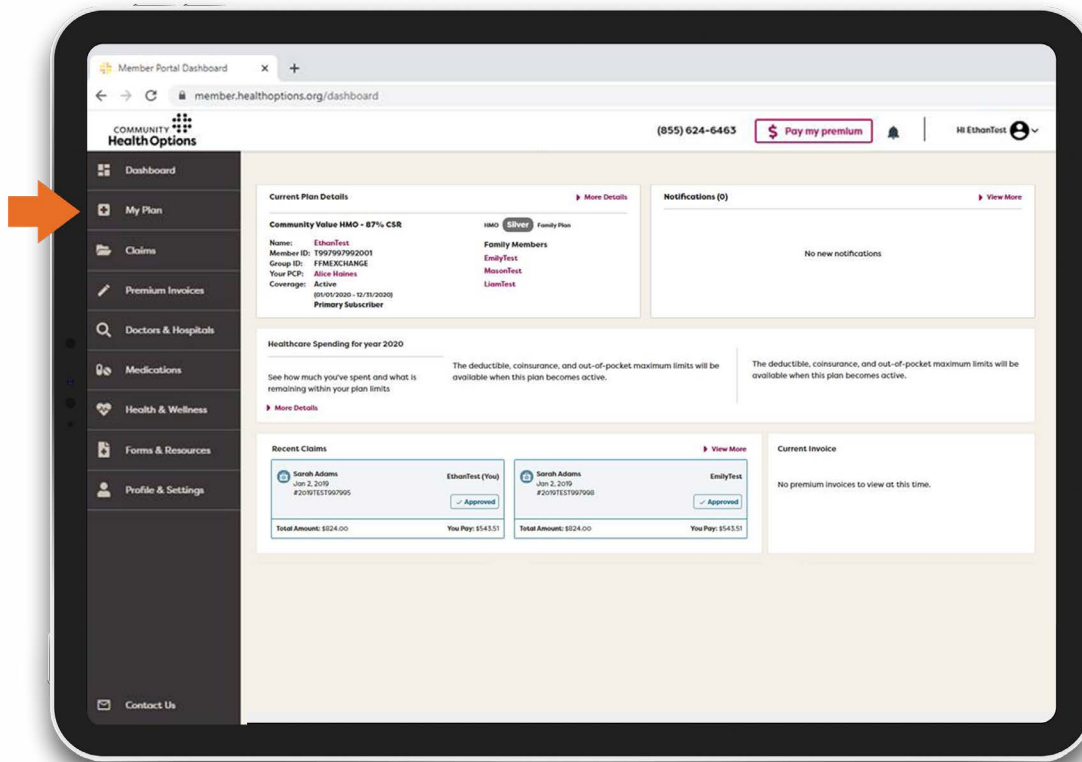
Plan Details	Individual	Family
INN Deductible	\$6,200	\$12,400
RN Maximum OOP	\$7,000	\$14,000
OCN Deductible	\$12,400	\$24,800
OCN Maximum OOP	\$14,000	\$28,000

Plan Name: Cornerstone Option PPO HSA \$6200 30% \$7000 Rx2 '21



Get to Know Your Dashboard

Once you set up your account, your **portal** displays your personal dashboard and **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



More ways to use the dashboard to manage your benefits.

ON YOUR DASHBOARD, FIND A PROVIDER OR PEDIATRICIAN

- Seeing a provider can take on many different meanings these days, depending on what you need, how you need it, and when. We have a variety of options to get you the medical help that's right for you. On your dashboard, Click on **Doctors and Hospitals** to select a provider.

ON YOUR DASHBOARD, FIND ESTIMATES FOR SERVICES

- In early 2023, use the new cost estimator tool to understand and compare the costs of the 500 most common shoppable products and planned services. On your dashboard, click on **Estimate My Costs** to learn more.

Use the new **cost estimator tool** to understand how to get the highest quality and best price for health services.

STAY INFORMED

- A list of preventive healthcare benefits are 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

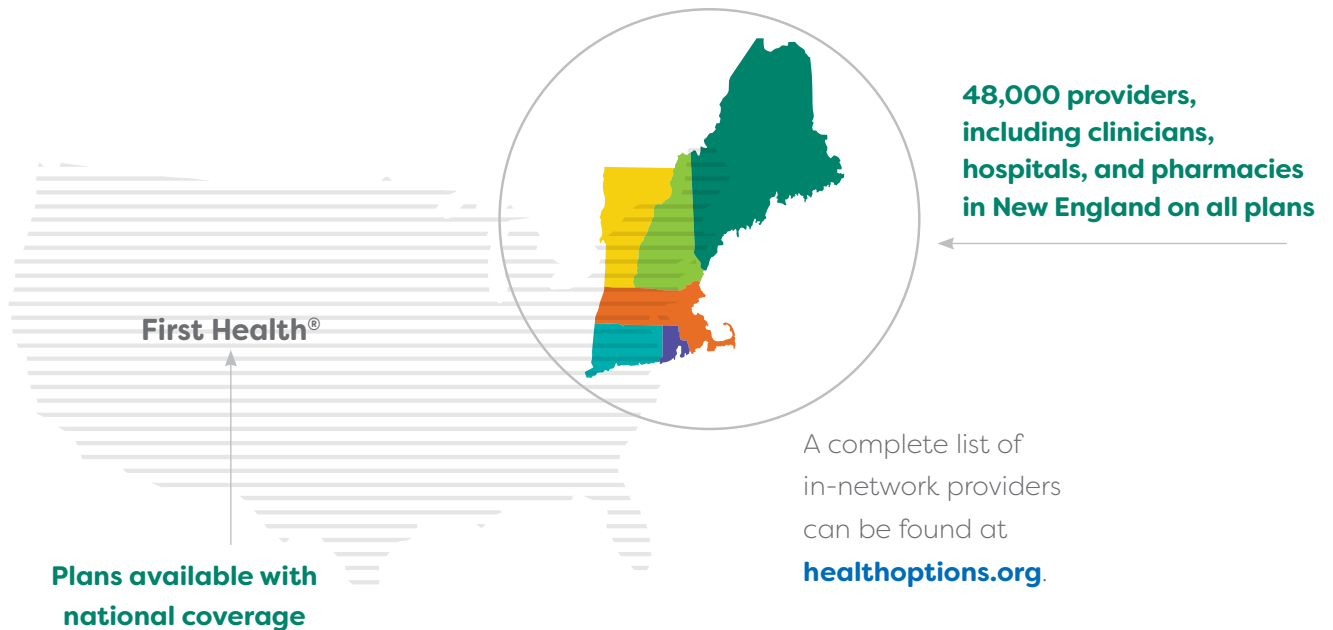
Many communications are sent electronically in your Member portal, such as Prior Approval letters, Explanation of Benefits, and invoices. It's simple, secure, and convenient. Plus, you can check your claims, see updates, and more. **If you prefer to receive paper documentation, contact Member Services.**

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



Network Providers

Health Options has a robust network of providers designed to make it easy and convenient for Members to receive care.



MEMBER NETWORK BY GEOGRAPHIC LOCATION		
Service Type	Within ME/NH	Outside ME/NH
Medical/Behavioral Health, Substance Use Disorder	Community Health Options' Service Area Network is broad within ME & NH and is available to all plans	Access to contracted providers on all plans and First Health on plans with national network
Pharmacy	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
- Newton-Wellesley Hospital
- North Shore Medical Center, Spaulding Hospital
- Springfield Hospital
- Dartmouth Hitchcock Hospital

*Except Togus VA Hospital



Network Providers

All plans have in-network access to our broad New England network. This includes US national or regional PPO plans, which also offer out-of-network coverage.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	PPO NE	PPO National
Medical, Behavioral and Substance Use Disorder	Health Options' New England network is broad within ME & NH and has a limited number of key providers in MA & VT. For services outside of ME, NH, MA and VT, there is out-of-network coverage*; however, there is higher cost-sharing.	National plans include in-network national coverage through the First Health® network. For providers outside of the Health Options network or First Health network, there is out-of-network coverage*; however, there is 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 your provider offers telehealth services, routine in-network and out-of-network rates will apply.	
Emergency Services	All plans cover emergency services in the emergency department at the in-network level of benefits in the United States.	
Pharmacy	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 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.
- 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.
- Plan preventive care visits with in-network PCP/PED providers based on the recommendations included at [healthcare.gov](https://www.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
<p>Primary Care Provider (PCP)/ Pediatrician (PED)</p> <p><i>The doctor, physician assistant, or nurse practitioner you chose when your Health Options coverage began</i></p>	<p>Call or visit your PCP/PED for:</p> <ul style="list-style-type: none"> • 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 	\$
<p>Walk-in Primary Care Service</p> <p><i>These facilities are associated with a PCP practice and have extended hours and walk-in service.</i></p>	<p>Use walk-in primary care when you need quick care for non-life threatening conditions.</p> <ul style="list-style-type: none"> • Sprains • Minor injuries that require stitches • Minor burns • Minor broken bones • Minor infections • Cold, flu, strep symptoms • Respiratory infections 	<p>\$-\$ \$</p> <p>(Costs may vary but will generally be less expensive than the emergency department of a hospital)</p>
<p>Urgent Care</p> <p><i>These are stand-alone, walk-in clinics</i></p> <p>Click here for a list of in-network urgent care locations.</p>	<p>Go to an urgent care center when you need quick care for non-life-threatening conditions.</p> <ul style="list-style-type: none"> • Sprains • Minor injuries that require stitches • Minor burns • Minor broken bones • Minor infections • Cold, flu, strep symptoms • Respiratory infections 	\$\$
<p>Amwell® Urgent Care Telehealth</p> <p><i>Online or over the phone visits with a clinically licensed urgent care provider.</i></p>	<p>Log in to Amwell® Urgent Care when you need quick care for non-life-threatening conditions.</p> <ul style="list-style-type: none"> • Headaches • Minor burns • Minor infections • Cold, flu, strep symptoms • Respiratory infections 	<p>No cost-share for all non-HSA plans; and \$0 after deductible for HSA plans</p>
<p>Emergency Department (ED) at a hospital</p>	<p>Go to the ED or call 911 for serious, life-threatening injuries or conditions:</p> <ul style="list-style-type: none"> • Large open wounds • Heavy bleeding • Chest pains • Sudden weakness or trouble talking • Major burns • Severe head injuries • Major broken bones • Difficulty breathing 	\$\$\$



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. Unlike other carriers, Health Options does not require you to wait the 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 your 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 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.



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



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 Screening Colonoscopies with no cost-share for Members aged 45 and older. Preventive health screening colonoscopies have no deductible, co-insurance or co-pay.



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.

**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](https://www.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?
- 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 [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](https://www.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 Centers 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 tests, are covered with no cost-share based on age and certain risk factors. Preventive service lab tests can be found at [healthcare.gov](https://www.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](#).
- Visit the Adult Preventive Services Guidelines 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

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

Primary Care

A Member's first primary care visit during a plan year has no cost-share in non-HSA plans. Tests and services provided during that visit may be subject to standard cost share. Unlike other carriers, Health Options does not require you to wait the 366 calendar days between visits to see your provider for annual preventive wellness care and checkups. These annual visits reset based on the date the plan coverage begins, not the date of a Member's last appointment. While it is best to schedule yearly preventive services approximately 12 months apart to get the maximum benefit, Members have some flexibility with appointment dates and peace of mind knowing their care is on their schedule. Annual wellness visits based on plan year include preventive wellness visits, mammograms, adolescent hearing screenings, low dose CT scans for lung cancer screening, labs, and immunizations.

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. The visit will have the same plan coverage as in-network or out-of-network provider office visits. They 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

Health Options is committed to prioritizing emotional wellbeing along with physical health. The **first three in-network, outpatient behavioral health visit for members or dependents has no cost-share** on non-HSA compatible plans for in-person or online/telephonic visits. Health Options will even cover a medical visit and a behavioral health visit on the same day, and we can facilitate same-day referrals.

Amwell® Telehealth

We offer telehealth for **urgent care, psychiatry, and counseling/therapy** through our partnership with American Well (Amwell). This option makes it easy and fast for Members and their dependents to access care. Both one-time and continued care behavioral health visits can be managed easily online, scheduling 7 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.**

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, 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 to get started.



Wellness Benefits

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. Members can access Healthwise materials in their Member portal.

Wellness Platform

Health Options partners with WellRight® on select plans to provide a digital wellness engagement platform and mobile app at no cost to Members 18 years and older. The program is rich with wellness challenges, a sense of community, gamification—including daily text nudges, an opportunity to earn rewards, and health education that is all geared toward driving positive habit formation and behavior change. The holistic and personalized approach guarantees a path toward better health.



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 are included on all plans (every 24-calendar-month period) with varying co-insurance, co-payment, or deductible requirements.

Oral Health

Many large employer group plans contract with New England Delta Dental (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

All non-HSA 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 illness, and helps reduce associated medical complications and unnecessary hospitalizations.

For CISP-eligible plans, Members with **asthma, coronary artery disease, chronic obstructive pulmonary disease, 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 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
<p>Office visits to the following providers:</p> <ul style="list-style-type: none"> • Primary Care Provider, Pulmonologist, Allergist for routine management of asthma • Palliative care conversations with provider to discuss chronic condition treatment • Immunotherapy for allergen sensitization <p>Also covered:</p> <ul style="list-style-type: none"> • 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 	<p>Office visits to the following providers:</p> <ul style="list-style-type: none"> • Primary Care Provider, Cardiologist for routine management of CAD • Palliative care conversations with provider to discuss chronic condition treatment <p>Also covered:</p> <ul style="list-style-type: none"> • 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 	<p>Office visits to the following providers:</p> <ul style="list-style-type: none"> • Primary Care Provider, Pulmonologist for routine management of COPD • Palliative care conversations with provider to discuss chronic condition treatment <p>Also covered:</p> <ul style="list-style-type: none"> • 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 <p>Note that oxygen delivery and supplies are subject to routine coverage.</p>	<p>Office visits to the following providers:</p> <ul style="list-style-type: none"> • Primary Care Provider, Endocrinologist, Podiatrist, Optometrist/Ophthalmologist for routine management of diabetes • Palliative care conversations with provider to discuss chronic condition treatment <p>Also Covered:</p> <ul style="list-style-type: none"> • 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 <p>Diabetic supplies specified on the formulary and dispensed via ESI home delivery are covered at \$0 cost-share:</p> <ul style="list-style-type: none"> • One glucometer per year • Glucose test strips: up to 150 strips every 30 days or 450 strips every 90 days <p>Note that insulin pumps and continuous glucose monitors and associated supplies are subject to routine coverage.</p>	<p>Office visits to the following providers:</p> <ul style="list-style-type: none"> • 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 <p>Also Covered:</p> <ul style="list-style-type: none"> • Nutritional Counseling, up to six (6) visits per year • Targeted laboratory tests for the routine management of hypertension



Pharmacy Management

Health Options' 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, see plan details. 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

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, 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.

Low Co-Pay Preferred Generic Medications (Tier 1)

All non-HSA plans offer Tier 1 preferred generic medications at a **\$5 or less co-pay for 30 days. 90 days of medication is available for a \$10 co-pay** 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 Preventive Drug Coverage

All group HSA Plus Plans include a carefully created list 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 as H.S.A. 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.

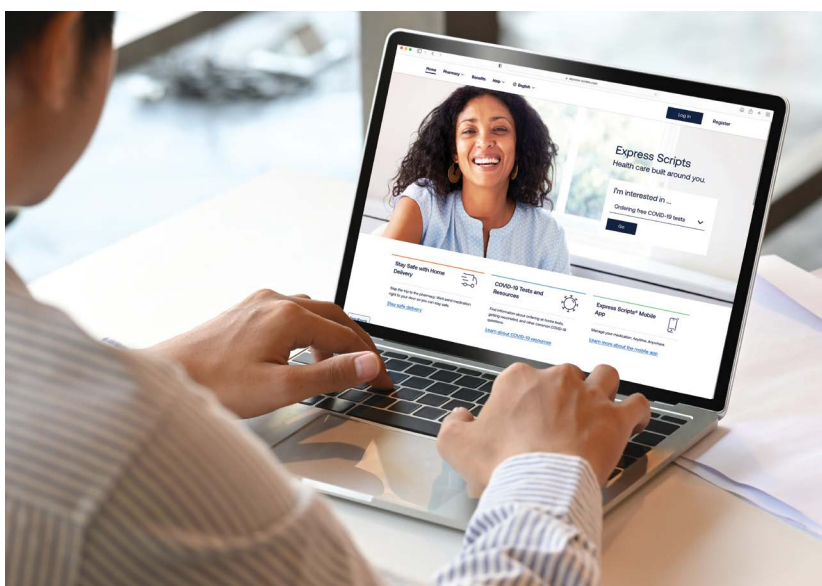
Members new to Health Options, or filling an insulin prescription for the first time will be engaged by our Care Management team and provided assistance, helping Members **save time and money** on their care.



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 Rx 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 employees. For more information on the drug formulary visit healthoptions.org.



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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 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 co-pay, you pay only two co-pays 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 clicking on the **Register** button and following the prompts.

*Certain limitations apply.

Express Scripts Mobile App

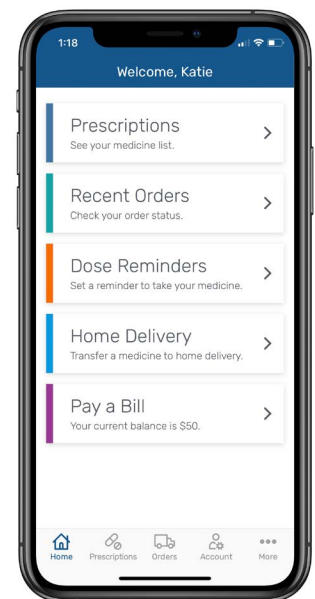
STAY ON TRACK WHILE YOU ARE ON THE GO

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, 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.

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**.



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](#) or call (877) 895-9697.



Pharmacy Success Story

Our Pharmacy team reached out to a Member with diabetes who was concerned about the high cost of her medication and the 1-hour drive to her pharmacy. The Pharmacy team noticed the Member had the Chronic Illness Support Program (CISP) as part of her health plan, and informed her of the program and the benefits of using mail order. After this very positive experience, the Member transferred all of her medications, as well as all of her husband's prescriptions to mail order. They now receive 3 months of medications by mail and **save over \$600 per month** in prescription costs.



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

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 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 **52% reduction** in readmission rate (2018–2021), 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 costs** 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 Association of 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 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 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 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.*
- 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.

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

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 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.



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

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](https://www.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.

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 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, Health Options 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.



Frequently Asked Questions (FAQs)

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.

What is covered vs. non-covered services?

Covered benefits are health services that your insurance policy pays for. You may be required to pay co-pays, co-insurance, 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 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.



Frequently Asked Questions (FAQs)

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.

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® Inc., 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 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, (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.

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