Large Group Member Guide 2025

COMMUNITY Health Options®

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Community Health Options Overview

Founded in 2011 and headquartered in New Gloucester, Maine, Community Health Options is a health insurance partner that understands your unique needs. We are a local, nonprofit option created to serve Members, not profit off them. We offer health insurance and wellness tools you deserve and can actually use, resulting in lower out-of-pocket costs and better health outcomes.

We work with a robust network of 48,000 providers including clinicians, hospitals and pharmacies in New England, as well as all hospitals in Maine and most in New Hampshire.* Our plans include PPO NE, PPO National, HMO Tiered NE and HMO National, as well as HSA Plus 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 Large Group Benefits

Welcome to Community Health Options! We are happy to have you as a Member. Now that you're 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! HSA Plus plans offer a **specially designed Chronic Illness Support Program** (CISP). All other plans continue to have our popular CISP program.

NEW! *Select* plans include **coverage for GLP-1 products** approved for weight loss.

First in-network primary care and first three behavioral healthcare visits each plan year have no cost share on non-HSA plans.

Access to Firefly Health, a virtual-first primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide, available on all plans.

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

$0 cost digital wellness platform and mobile app for Members 18 years and older.

$0 cost unlimited personalized health coaching available through the wellness platform to Members 18 years and older on services such as nutrition, fitness, heart health and more.

Copay for in-network acupuncture on non-HSA plans and up to $50 reimbursement on HSA plans with no deductible. All plans offer up to $50 reimbursement for out-of network providers.

Copay for adult and pediatric vision exams on most non-HSA plans and lenses/frames/contacts with coinsurance after deductible.

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

NON-HSA MEMBERS HAVE VALUABLE COPAY BENEFITS:

- **$75 copay** for specified **X-ray locations**
- **$25 copay** for labs at specified **lab locations**
- **$0 or $5 copays** on 30-day Tier 1 preferred generic medications
- **Copays** on most plans for annual pediatric and adult vision exams
- **Copays** on most plans for physical, occupational, and speech therapy visits, as well as chiropractic and osteopathic adjustments
- **Copays** on all in-network acupuncturists with no deductible
- **Copays** for urgent care with reduced cost at specified **urgent care locations**

*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**.*

Finding Important Information About Your Plan

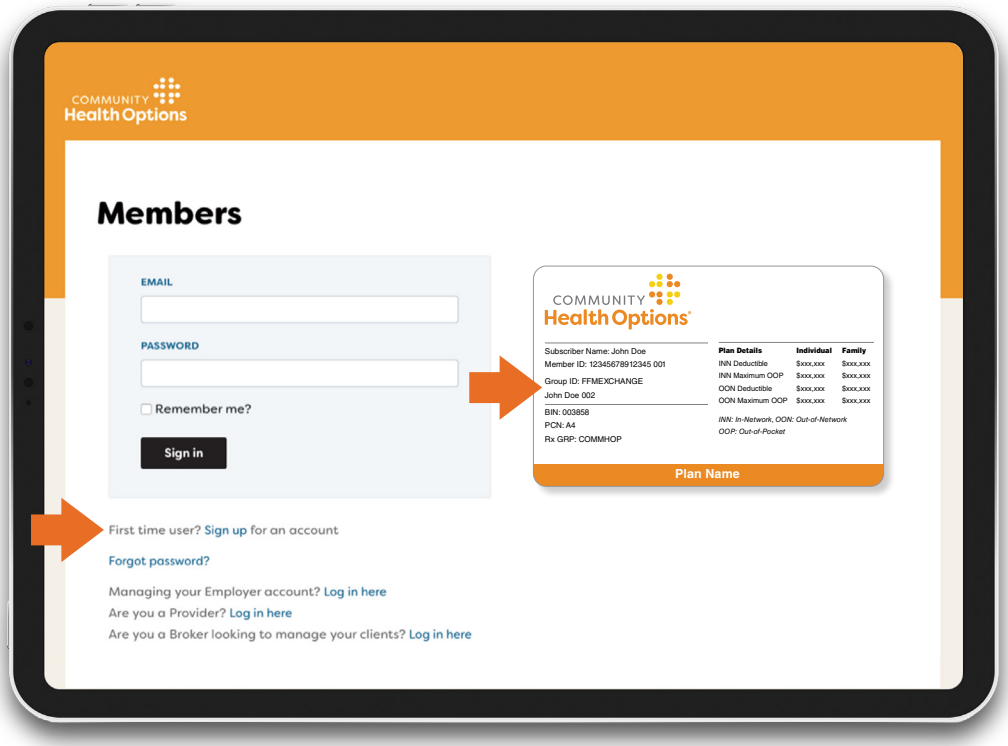
When you enrolled, you received a welcome packet with a Member ID card and instructions to set up your online portal. The Member portal provides access to plan benefits, claims, paperless delivery, primary care provider (PCP)/pediatrician (PED) selection and more. You'll also find a protected health information (PHI) release form to complete, which gives Community Health Options permission to release your personal health information to the person you choose, like a family member or caregiver. The 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:

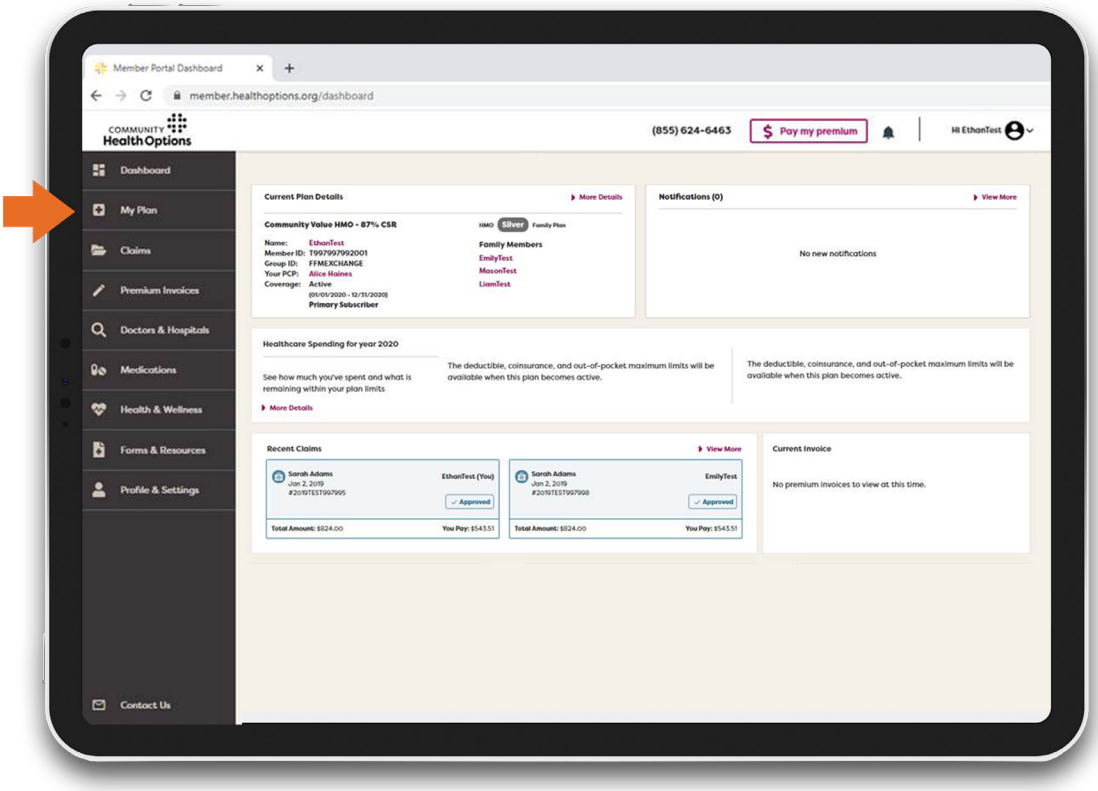
- Go to **healthoptions.org**.
- Click on **Sign In** at the far right upper corner of the screen.
- Select **Member Login**.
- Click on **First Time User? Sign up for an account**.
- At the next screen, enter your Member ID number, last name and date of birth.



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, under Benefits and Coverage click Health Plan Information:

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

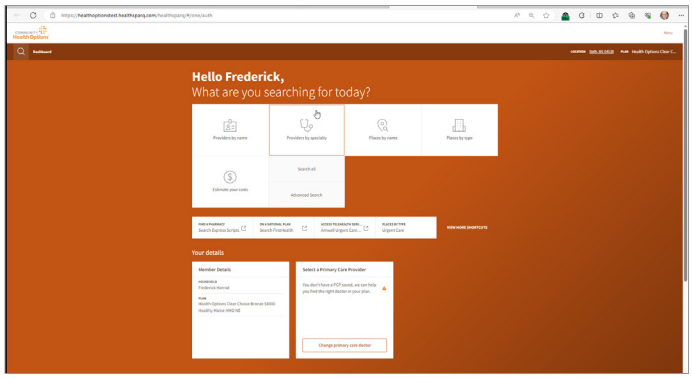
A summary of services, benefit limits and cost sharing responsibilities under your health plan.

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®**, a source for 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, 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** at (855) 624-6463 from 8 a.m. to 6 p.m., Monday through Friday, or by submitting this **contact form**.

Navigating Your Network

NETWORK TYPES – What's the Difference?

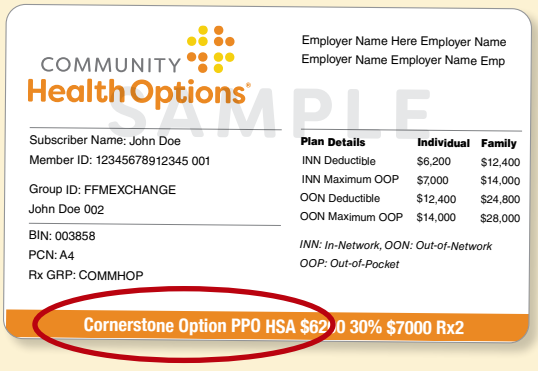
New England (NE) – Our **broad New England network** features more than 48,000 providers, including clinicians, hospitals and pharmacies in **Maine, New Hampshire, Vermont and Massachusetts**. All of our plans include the New England network.

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 many premier institutions.

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

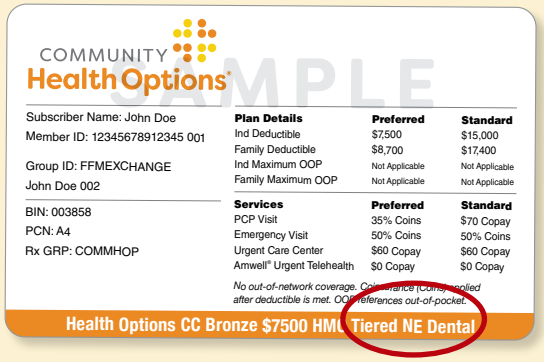
Look at your Member ID card to find your plan type, **HMO** or **PPO**. You can learn more about HMO and PPO plans on the following pages.



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.

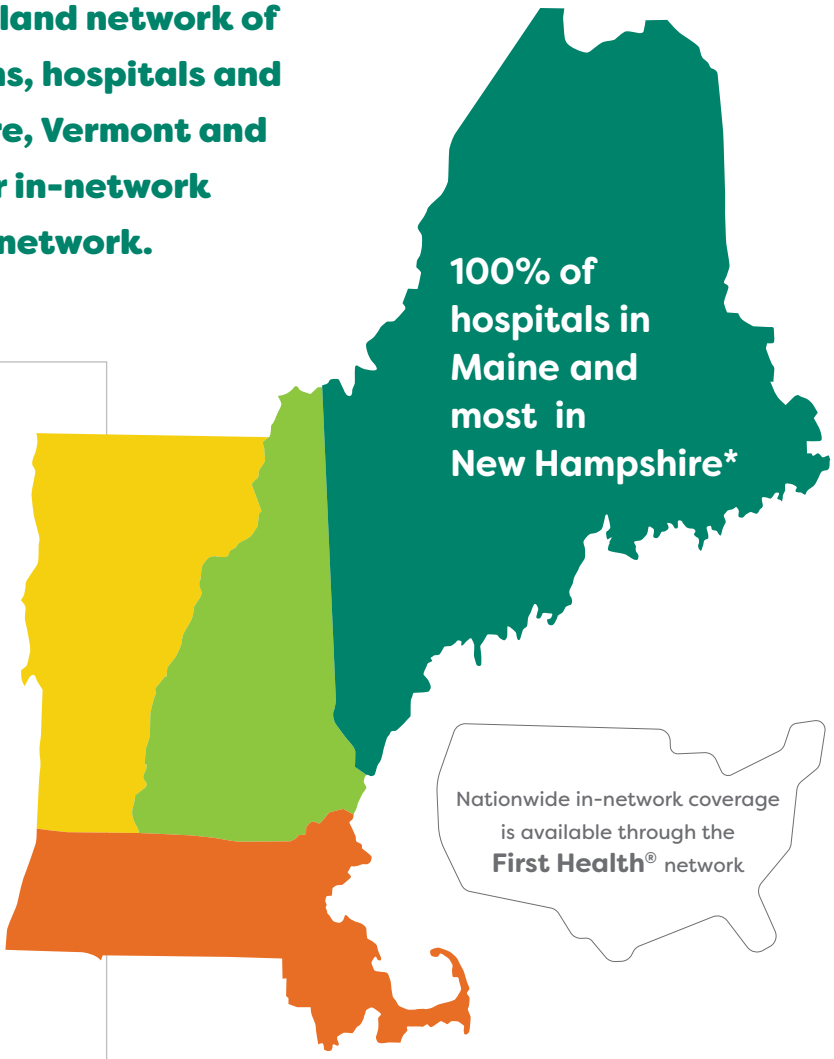
Network Providers

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 in-network coverage through the First Health® network.

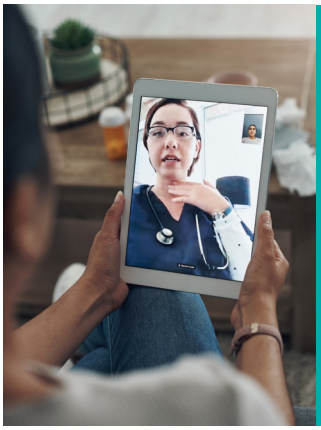
While our network comprises **100% of hospitals in Maine and most in New Hampshire**, it extends well beyond these states, including many premier institutions within New England.*

- Boston Children's Hospital
- Brigham and Women's Faulkner Hospital
- Brigham and Women's Hospital
- Dana-Farber Cancer Institute
- Dartmouth Hitchcock Hospital
- Mass Eye & Ear
- Massachusetts General Hospital
- McLean Hospital
- Newton-Wellesley Hospital
- Salem Hospital
- Spaulding Hospital
- Springfield Hospital
- Walden Behavioral Care LLC

*All Maine hospitals, except Togus VA Hospital



A complete list of in-network providers can be found in your **Member portal**



Firefly Health: Virtual-First Primary Care

Alongside its traditional provider network, Community Health Options offers Members 18 years and older the option of using a virtual-first primary care team through Firefly Health. Members can choose a virtual primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide.

To learn more, visit Firefly Health.

Network Providers–HMO

All HMO plans offer in-network coverage through our broad New England network. HMO Tiered plans provide access to high-quality preferred providers at lower cost sharing, and HMO National plans offer national in-network coverage through the First Health network.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	HMO Tiered NE	HMO National
Medical, Behavioral and Substance Use Disorder	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.***	Community Health Options' broad New England network, plus **national in-network coverage**, provides access to thousands of hospitals and almost 1 million professional providers.
	**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. All plans offer in-network telehealth through Amwell® for behavioral health and urgent care, as well as primary care through Firefly Health.	
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 offer national in-network coverage through the First Health® network.

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 direct contracts with key providers in **MA & VT**. *For services outside of New England, out-of-network coverage is available with higher cost sharing.**	Community Health Options' broad New England network, plus **national in-network coverage**, provides access to thousands of hospitals and almost 1 million professional providers.
	**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.*	
Telehealth	If a provider offers telehealth services, routine in-network and out-of-network rates will apply. All plans offer in-network telehealth through Amwell® for behavioral health and urgent care, as well as primary care through Firefly Health.	
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

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 find 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.
- For easy access, consider selecting an in-network virtual primary care team at Firefly Health. Learn more by visiting **Firefly Health**.

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 $0 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

Site of Service

RECEIVING CARE AT SPECIFIED LOCATIONS CAN SAVE YOU MONEY

You pay less for your care by choosing specific sites for lab tests and X-rays. Members have a copay with no deductible at these specified locations, rather than paying coinsurance after the deductible. HSA Members also have a copay once their deductible is met.

You can find site-of-service locations by clicking the links below.

$25 copay on labs at specified locations. Click here.

$75 copay on X-rays at specified locations. Click here.

On select plans, Members also save when they visit specified freestanding urgent care locations or use Firefly Health for primary care services.

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. This includes virtual primary care through Firefly Health. **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 A walk-in clinic is a healthcare facility that provides convenient basic medical care and can usually be found near pharmacies or retail stores. These services are generally 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 lower than in a hospital emergency department.

Network Providers

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 **$0 after deductible for HSA plans.**
Urgent Care These are stand-alone, walk-in clinics. For a list of in-network urgent care locations, visit the provider directory in your Member portal. An easy, printable reference list may also be found in your portal, under Forms and Resources.	**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

Your plan covers many preventive healthcare services, including screenings, checkups and counseling at no cost. You are not required to wait 365 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 began, not the date of your last appointment. While it is best to schedule your yearly preventive services approximately 12 months apart to get the maximum benefit, you have some flexibility with appointment dates—peace of mind knowing your care is on your schedule. Refer to your plan documents for details on all covered preventive services.

Take advantage of **adult and pediatric preventive care** benefits, outlined by state and federal laws, which are covered at no cost when performed by in-network providers.

Full coverage for a yearly **influenza/flu vaccination** is available for adult and pediatric Members when administered by an in-network provider (doctor or pharmacy).

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 provided when you or your family members are symptom-free and have no reason to be concerned. 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 at no cost to you.

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 at (855) 624-6463, from 8 a.m. to 6 p.m., Monday through Friday, or by submitting this **contact form**.

Preventive Care

Commonly Asked Preventive Services Questions

Where can I find a list of 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 2025 may not be covered as a preventive service until 2027.*

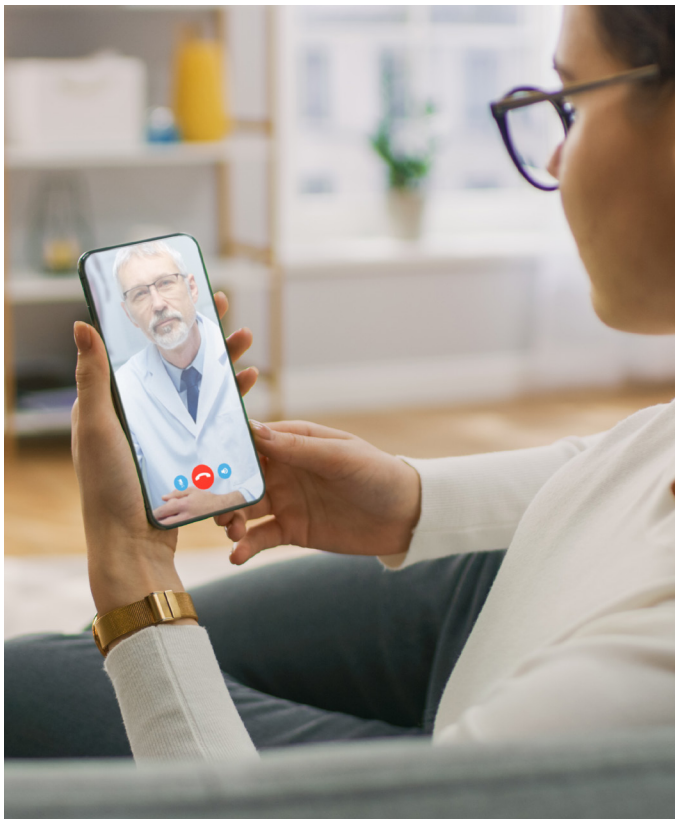
Wellness Benefits

For easy access to these resources and services, set up your Member portal at **healthoptions.org**.

Primary Care and Behavioral Health

There is no cost for your first three in-network behavioral health visits or your first primary care visit during a plan year (Members on an HSA plan have coinsurance after deductible cost sharing). Tests and services provided during your primary care visit may be subject to standard cost sharing. Your plan covers many preventive healthcare services, including screenings, checkups and counseling at no cost. For more information about preventive wellness, please refer to the Preventive Care section of this guide or your plan documents.

Virtual Care Options



A provider visit can be just a click away. Virtual care services make it easy for you to schedule appointments and access urgent care needs, all from your phone or tablet, whenever and wherever you want.

- If your provider offers telehealth services, the visit will have the same plan coverage as in-network or out-of-network in-person office visits.
- **Members can access Firefly Health, a virtual primary care option available to Members 18 years and older.** Firefly Health offers a virtual primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide. To learn more, visit **Firefly Health**. Visits will have the same plan coverage as in-network primary care office visits.
- **All plans include telehealth for urgent care, psychiatry and counseling/therapy through Amwell®**. One-time and continued behavioral healthcare visits can be easily managed. Urgent care telehealth is available 24/7, providing access to treatment whenever it's needed. 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. You'll find details on copays, coinsurance, and any visit limitations in your plan documents.

Wellness Benefits

Acupuncture

All plans have coverage for acupuncture services with a copay for in-network providers on non-HSA plans, and up to $50 reimbursement for out-of-network providers. HSA plan Members can get in and out-of-network reimbursement up to $50 per visit with no deductible. You'll find details in your plan documents.

Vision

All plans offer adult and pediatric vision coverage including one eye exam every 12-month calendar year. On most non-HSA plans, pediatric and adult exams are with a copay. All plans include coverage for lenses, frames and contacts (every 24-month calendar period) with deductible and varying coinsurance amounts.

Oral Health

Your employer may contract with Northeast Delta Dental® to provide dental coverage for both pediatric and adult Members on select plans. 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

Healthwise® provides evidence-based, medically reviewed health information 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 find a link to Healthwise in your Member portal through the Health & Wellness tab.

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. Benefits include gamified wellness challenges, integration with wearable devices, and a comprehensive health assessment. The holistic and personalized approach guarantees a path toward better health. Members with this program can access their account through the Health & Wellness tab in the Member portal, download the WellRight app, or log on to **healthoptions.wellright.com**. When you download the mobile app you will need to enter the company code "healthoptions" to begin your personalized experience.

Unlimited Personalized Health Coaching

Unlimited personalized health coaching is available through the wellness platform to Members 18 years and older at no cost. 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. Members can use free health coaching through the wellness platform to quit tobacco. Care managers can also help them find additional resources.

Care Management

Our care teams 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 teams also partner with a range of local agencies that offer or can connect you with community support.

Chronic Illness Support Program

Non-HSA plans include a 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—with $0 cost on select medical services listed below. Additionally, Members can save on CISP-designated medications when ordering through the Express Scripts (ESI) mail-order pharmacy. See below for details on services and pharmacy.

FOR NON-HSA PLANS ONLY

CHRONIC ILLNESS SUPPORT PROGRAM (CISP) MEDICAL SERVICES				
Asthma	**Coronary Artery Disease (CAD)**	**Chronic Obstructive Pulmonary Disease (COPD)**	**Diabetes**	**Hypertension**
Office visits for care related to asthma for: • Primary care, pulmonologist, allergist for routine management • Palliative care to discuss 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 routine management	**Office visits for care related to CAD for:** • Primary care, cardiologist for routine management • Palliative to discuss condition treatment **Also covered:** • Electrocardiogram (ECG) • Nutritional counseling, up to 12 visits per year • Cardiac rehabilitation & associated exercise programs are covered at 50% cost share reduction • Targeted laboratory tests for routine management	**Office visits for care related to COPD for:** • Primary care, pulmonologist for routine management • Palliative care to discuss condition treatment **Also covered:** • Inhaler adjuncts (e.g., holding chamber/spacer) through mail order • Pulmonary function tests • Home oxygen therapy assessment • Pulmonary rehabilitation & associated exercise program are covered at 50% cost share reduction • Targeted laboratory tests for routine management **Note: Oxygen delivery and supplies are subject to routine coverage.**	**Office visits for care related to diabetes for:** • Primary care, endocrinologist, podiatrist, optometrist/ophthalmologist for routine management • Palliative care to discuss condition treatment **Also covered:** • Nutritional counseling, up to 12 visits per year • Diabetes education with a certified diabetes educator • Targeted laboratory tests for routine management **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 • Monthly FreeStyle Libre Continuous Glucose Monitoring system sensors **Note: Aside from FreeStyle Libre, all other continuous glucose monitors, insulin pumps, and associated supplies are subject to routine coverage.**	**Office visits for care related to hypertension for:** • Primary care for routine management • Cardiologist and nephrologist for consultation and routine management • Palliative care to discuss condition treatment **Also covered:** • Nutritional counseling, up to 12 visits per year • Targeted laboratory tests for routine management • Blood pressure cuff
Pharmacy Benefits include:	• **Select Tier 1 Generic Medications** designated with CISP on the drug formulary at $0 with ESI mail order on 35+ days of medication. • **Select Tier 2 and 3 Medications** designated with CISP on the drug formulary at 50% cost share reduction with ESI mail order on 35+ days of medication and maximum savings with 90-day supply.			

All other drug tiers and drugs without an HSA+ designation on the most current drug formulary require routine cost sharing. Talk with your provider about whether a lower-tier medication is available for your chronic illness.

Large Group HSA Plus Chronic Illness Support Program

All Large Group HSA Plus plans include a specially designed Chronic Illness Support Program (CISP) that meets the preventive requirements of high deductible health plans. Our goal is to support Members with asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes and hypertension in improving their health and well-being.

To make this possible, select medical services for preventive care or screening are available with no copay or coinsurance, and no deductible, when performed by an in-network provider. Additionally, select Tier 1, 2 and 3 medications designated as HSA+ are available with copay or coinsurance, with no deductible required.

FOR HSA PLUS PLANS

CHRONIC ILLNESS SUPPORT PROGRAM (CISP) MEDICAL SERVICES

Asthma	Coronary Artery Disease (CAD)	Chronic Obstructive Pulmonary Disease (COPD)	Diabetes	Hypertension
Up to 3 primary care visits and 1 specialist visit annually (allergist or pulmonologist) for care related to asthma. • Pulmonary function test management • Asthma education during an office visit • Targeted laboratory tests for the routine management of asthma **Also covered:** • Inhaler adjuncts (e.g. holding chamber/spacer) through ESI mail order	**Up to 3 primary care visits and 1 specialist visit annually (cardiologist) for care related to CAD.** • Nutritional counseling, up to 12 visits per year at $0 cost **Also covered:** • Electrocardiogram (ECG) • LDL laboratory test	**Up to 3 primary care visits and 1 specialist visit annually (pulmonologist) for care related to COPD.** • Pulmonary function test • Home oxygen therapy assessment • Targeted laboratory tests for the routine management of COPD **Also covered:** • Inhaler adjuncts (e.g., holding chamber/spacer) through mail order **Note: Oxygen delivery and supplies are subject to routine coverage.**	**Up to 3 primary care visits and 1 specialist visit annually (endocrinologist, podiatrist or optometrist/ophthalmologist) for care related to diabetes.** • Nutritional counseling up to 12 visits per year at $0 cost share • Retinopathy screening • Diabetes education with a certified diabetes educator • A1C laboratory tests **Also covered:** • One glucometer per year • Glucose test strips: up to 150 strips every 30 days or 450 strips every 90 days • Monthly FreeStyle Libre Continuous Glucose Monitoring system sensors **Note: Aside from FreeStyle Libre, all other continuous glucose monitors, insulin pumps, and associated supplies are subject to routine coverage.**	**Up to 3 primary care visits and 1 specialist visit annually (cardiologist or nephrologist) for care related to hypertension.** • Nutritional counseling up to 12 visits per year at $0 cost share **Also covered:** • Blood pressure screening • Blood pressure monitoring • Blood pressure cuff

- **Select Tier 1, 2 and 3 medications** designated as **HSA+** on the drug formulary are available with copay or coinsurance, with no deductible required at in-network retail pharmacies.
- **Additional savings are offered through ESI mail order** with two 30-day copays or coinsurance payments for 90 days of medication.

All other drug tiers and drugs without an HSA+ designation on the most current drug formulary require routine cost sharing. Talk with your provider about whether a lower tier medication is available for your chronic illness.

Pharmacy Management

Our in-house pharmacists support the development of competitive and cost-effective prescription drug formularies in partnership with Express Scripts, a Pharmacy Benefit Manager. 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

We offer you several ways to make it easier to take prescribed medications. The **Price Assure** program automatically saves you money on generic medications when you take prescriptions to in-network pharmacies that also accept GoodRx®. By using your health insurance Member ID card, you get any possible savings while the cost applies to your deductible and out-of-pocket costs. Through the **Medication Synchronization** program, our Pharmacy team works directly with Members who are prescribed three or more maintenance medications 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 on your behalf with providers and pharmacies to find cost-saving opportunities, including manufacturers' coupons.

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.

Pharmacy Management

Low Copay Preferred Generic Medications (Tier 1)

All non-HSA plans offer Tier 1 preferred generics at **$0 or a $5 copay for 30 days**. When using Express Scripts home delivery, 90 days of medication is available for two 30-day copays when filling medications. HSA Plus plans offer select medications designated HSA+ on the formulary, with cost-share and no deductible.

HSA Plus Enhanced Preventive Drug Coverage

HSA Plus plans have a special list of medications to help prevent the development of and reduce the risk of complications due to chronic conditions and illnesses. These prescription drugs, designated as **HSA+** on the formulary, bypass the deductible and require Members to pay only the applicable coinsurance or copayment amounts. To view the **HSA+**-designated drugs, review the formulary at **healthoptions.org**.

Pharmacy Benefit Manager

The Express Scripts portal gives you a high degree of control over your prescription orders and costs with medication comparisons and suggestions for lower priced options. **Importantly, our Pharmacy team found that 90% of prescriptions filled for our Members were generics—saving them money and helping them to stay on schedule with their medications.** 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.**

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. Our pharmacy network gives you access to retail pharmacies throughout the country, as well as access to mail order through Express Scripts.

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

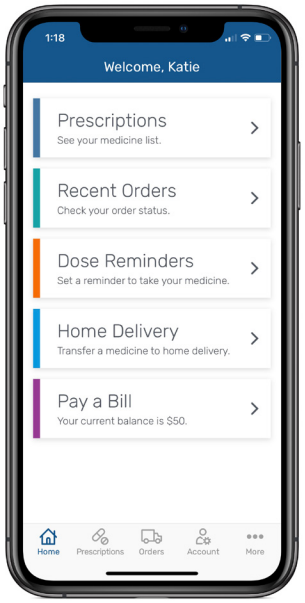
- Express Scripts provides help with prescription-related information and services through its own website.
- Register with Express Scripts by going to the portal's Medications section and clicking **Get started / Log in.**

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 or face 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, all healthcare professionals, 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 switching from a prior health plan will be paired with a Complex Care Manager to ensure a seamless transition.
- Members identified with high health risks have access to complex care management resources.

HOSPITAL READMISSION PREVENTION PROGRAM

With only about 5% of Members readmitted to the hospital within 30 days of discharge, we are working hard to help Members stay at home 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)

INFUSION SITE OF CARE PROGRAM

Our voluntary **Infusion Site of Care Program** has saved millions of dollars in healthcare costs for Members by offering them 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. The 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 you the **healthcare benefits you expect and deserve.**

Care Management Success Story

A Northern Maine couple chose to have their premature baby boy at a city hospital several hours away so they could get the specialized care their baby needed. But the commute put an incredible strain on Mom and Dad and their two other children. Once the baby was doing well, care managers worked with the family and providers to move him to a hospital closer to home and transfer his care to the same local pediatrician who would hopefully care for him through his childhood.

Member Services

Member Service Excellence

Our Maine-based, in-house customer service representatives work from Kittery to Fort Kent, 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, 97% for receipt of information needed and 98% for 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
97%	satisfaction for receipt of information needed
98%	satisfaction for speed of answer

"I am a subscriber AND a provider. As a psychotherapist, I regularly call Community Health Options and have uniformly excellent experiences. Their customer service is outstanding. There are very short hold times—if any—and the customer service folks are knowledgeable, efficient, polite and kind. In the last 12 months, I have called Community Health Options 8 or 9 times and always had my questions answered politely and promptly. Proud that I live in Maine and have a GREAT Maine company that serves me professionally and personally." — Google Review

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 encourage 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 an HMO Tiered 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.

What is a Health Savings Account (HSA)?

An HSA, or Health Savings Account, is a specialized account for individuals with qualifying high deductible health plans (HDHPs). These accounts are a tax-free way for Members 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. It's important to recognize that only specific HDHPs are compatible with HSAs, and not all plans with high deductibles meet the requirements. For detailed guidance on whether your plan qualifies and to understand the associated tax benefits, it is recommended to seek advice from a tax professional.

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. They may assist you in your interactions with specialists.

What happens if my healthcare eligibility changes?

If you experience a life change, such as changing jobs, 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 a 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 Community Health Options or the First Health network 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.

Note: First Health Network is available only on select plans. Refer to plan documents and your ID card to determine availability.

What happens if I need to use my plan while out of the country?

All plans cover emergency services in the emergency department at the in-network level of benefits in the United States. All Large Group plans include coverage to care for emergent conditions outside the country, which may be paid by way of reimbursement. 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 deemed safe and effective. All plans include a carefully curated prescription drug formulary that emphasizes the prevention of chronic conditions and illnesses. Our formulary includes drug designations to indicate whether the drug requires Prior Authorization (PA), is covered under the Chronic Illness Support Program (CISP) or 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 located in your Member portal.

Frequently Asked Questions (FAQs)

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, copays, deductibles, and coinsurance are your out-of-pocket costs. Non-covered services are not included in out-of-pocket costs.

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 benefit plan 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 before 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 Maine-based Members Services team members earn high marks for providing accurate information with courtesy and respect. Give them a call with your questions at (855) 624-6463, 8:00 a.m. to 6:00 p.m., Monday through Friday.

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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