



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

Member Guide 2024

Table of Contents

► CLICK ON ANY TITLE TO JUMP TO THAT SECTION

- 3** [Community Health Options Overview](#)
- 4** [Overview of Benefits](#)
- 5** [Finding Important Information About Your Plan](#)
- 6** [Get to Know Your Member Portal](#)
- 8** [Navigating Your Network](#)
- 9** [Network Providers](#)
- 10** [Network Providers - HMO](#)
- 11** [Network Providers - PPO](#)
- 15** [Preventive Care](#)
- 18** [Wellness Benefits](#)
- 20** [Wellness Programs & Tools](#)
- 21** [Chronic Illness Support Program](#)
- 22** [Pharmacy Management](#)
- 26** [Medical and Care Management](#)
- 28** [Member Services](#)
- 29** [Frequently Asked Questions \(FAQs\)](#)
- 34** [Contact Information](#)



Community Health Options Overview



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

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

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

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



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

*All Maine hospitals, except Togus VA Hospital.



Overview of Benefits

Welcome to Community Health Options! We are pleased to have you as a Member. Most of our plans include the following benefits:



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



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



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



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



100% of the preventive care benefits required by the Affordable Care Act and the State of Maine at **no out-of-pocket cost** for in-network providers.



Full coverage for flu and COVID-19 vaccinations at in-network providers each flu season for all adult and pediatric Members.



Pediatric and adult vision coverage with one exam every 12-month calendar year. Adult exams are with deductible and coinsurance, and on non-HSA plans, pediatric visits are with a copay. Pediatric coverage also includes lenses, frames and contacts every 24-month calendar period.



Treatment for tobacco use at \$0 out-of-pocket cost with 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.



NEW! Coverage for **chiropractic and osteopathic adjustments** with a copay on all non-HSA plans.*



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



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



A **cost estimator tool** in your portal helps you understand and compare the costs of planned services.



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

PLAN SPECIFIC DETAILS



HSA plans labeled HSA Plus include prescription coverage for select drugs without a deductible.



Healthy Maine plans include WellRight®, a digital wellness platform and mobile app. Benefits include **unlimited personalized health coaching** at \$0 cost share, gamified wellness challenges, integration with wearable devices, a comprehensive health assessment and reward incentives.



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

* Not available on catastrophic plans.

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. ©2024 Community Health Options. All rights reserved.



Finding Important Information About Your Plan

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

Getting Started Online: Your Portal

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

HERE'S HOW TO GET STARTED:

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

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

Plan Details	Individual	Family
IN Deductible	\$xxxxx	\$xxxxx
IN Maximum OOP	\$xxxxx	\$xxxxx
ODN Deductible	\$xxxxx	\$xxxxx
ODN Maximum OOP	\$xxxxx	\$xxxxx

IN: In-Network, ODN: Out-of-Network
ODP: Out-of-Pocket

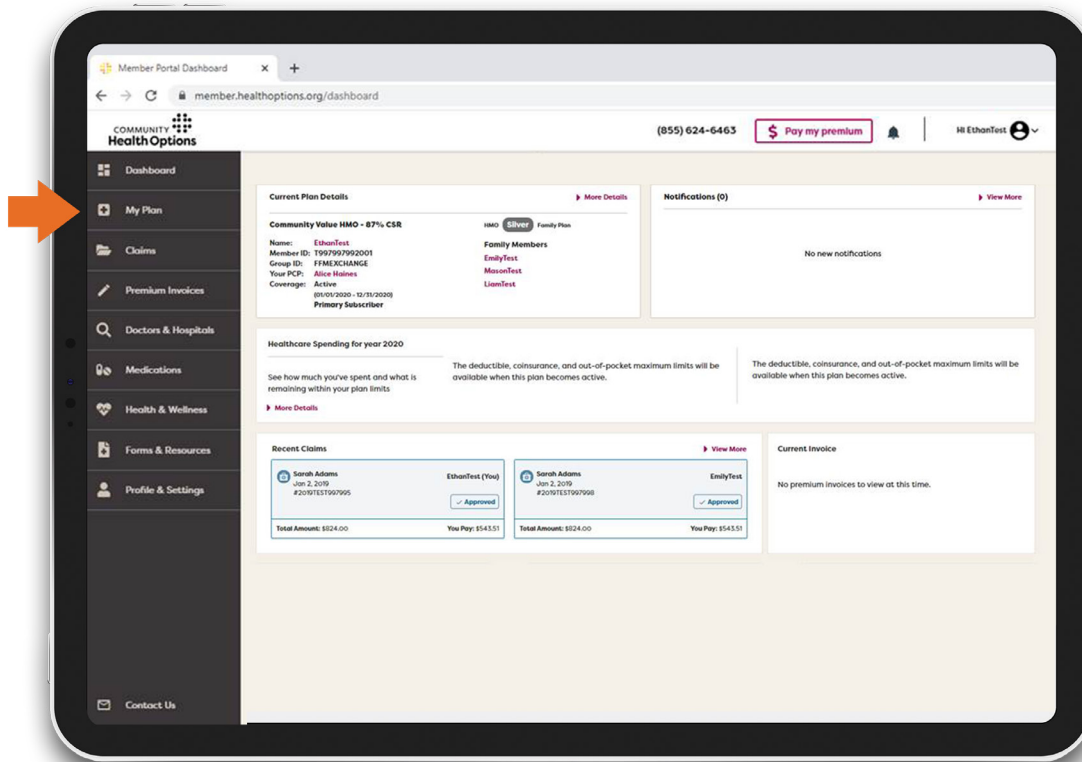
Plan Name:



Get to Know Your Member Portal

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

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



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

MEMBER BENEFIT AGREEMENT

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

SUMMARY OF BENEFITS AND COVERAGE

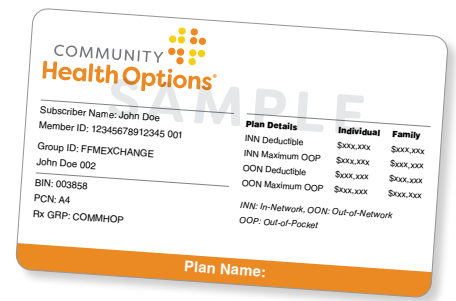
An overview of your plan benefits, including your potential out-of-pocket costs.

SCHEDULE OF BENEFITS

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



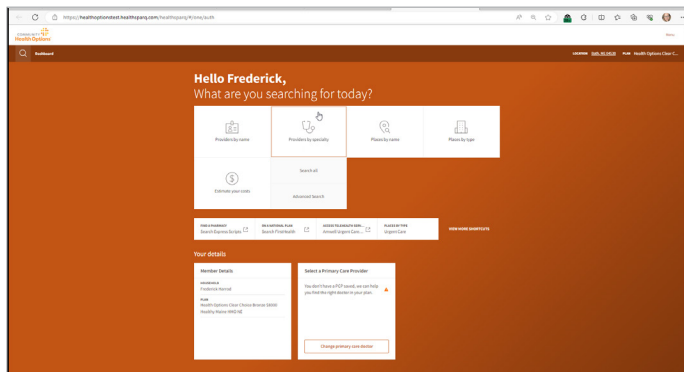
Get to Know Your Member Portal



More ways to use your portal to manage your benefits:

FIND A PROVIDER FOR YOURSELF OR A FAMILY MEMBER

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



FIND ESTIMATES FOR SERVICES

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

STAY INFORMED

- A list of preventive healthcare benefits 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 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.**

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](#).



Navigating Your Network

NETWORK TYPES – What’s the Difference?

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

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

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

1 Find your plan type

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

COMMUNITY HealthOptions

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

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

INN: In-Network, OON: Out-of-Network
OOP: Out-of-Pocket

Plan Name: Cornerstone Option PPO HMO \$6200 30% \$7000 Rx2

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**.

COMMUNITY HealthOptions

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

Plan Details	Preferred	Standard
Ind Deductible	\$7,500	\$15,000
Family Deductible	\$8,700	\$17,400
Ind Maximum OOP	Not Applicable	Not Applicable
Family Maximum OOP	Not Applicable	Not Applicable

Services	Preferred	Standard
PCP Visit	35% Coins	\$70 Copay
Emergency Visit	50% Coins	50% Coins
Urgent Care Center	\$60 Copay	\$60 Copay
Amwell® Urgent Telehealth	\$0 Copay	\$0 Copay

No out-of-network coverage. Coinsurance (Coins) applied after deductible is met. OOP refers to out-of-pocket.

Plan Name: Health Options CC Bronze \$7500 (MO Tiered NE Dent)

Network type

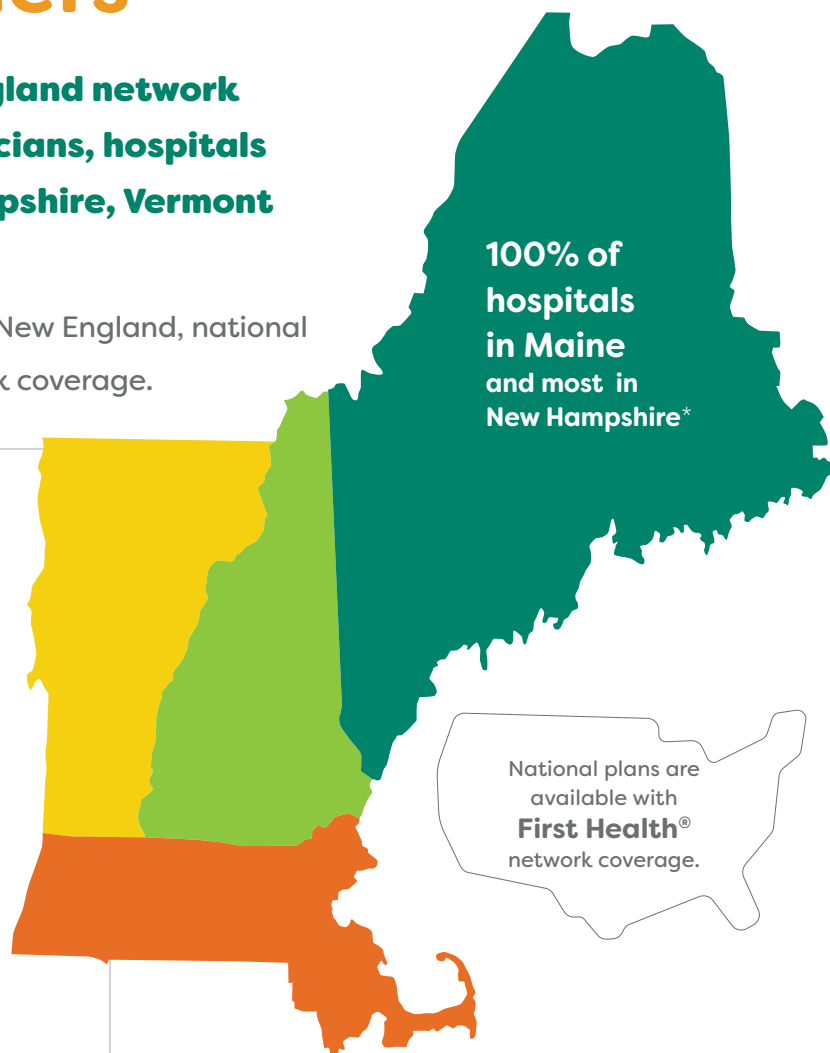
Find your plan and network type at the bottom of your card.



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.

If Members anticipate needing care beyond New England, national plans are available with First Health® network coverage.



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.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

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

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



Network Providers—HMO

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

Our HMO tiered plans offer an even more affordable option that includes the same New England network, but offers reduced copays or coinsurance when Members choose a preferred tier provider. **Unlike other tiered plans, our tiered plans include preferred providers in Maine, New Hampshire, Vermont and Massachusetts.**

HMO plans do not include out-of-network coverage except for emergency care within the U.S.

Note: Off-Marketplace Small Group HMO plans include access to care for emergent conditions outside the U.S.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	HMO NE	HMO Tiered NE	HMO National
Medical, Behavioral and Substance Use Disorder	Community Health Options' broad New England network includes providers across ME & NH as well as a limited number of key providers in MA & VT .*	Offers in-network access to Community Health Options' broad New England network with reduced copays or coinsurance for preferred tier providers .* A lower deductible and out-of-pocket maximum applies for preferred providers. Standard providers have a standard copay, coinsurance, deductible and out-of-pocket maximum. <i>All preferred provider cost sharing is applied to both the preferred and standard out-of-pocket maximum.</i>	Offers in-network access to Community Health Options' broad New England network , as well as national coverage through the First Health® network.*
<i>*There is no out-of-network coverage except for emergency care within the U.S.</i>			
Telehealth	If a provider offers telehealth services, routine in-network and out-of-network rates will apply . In-network telehealth through Amwell® for behavioral health and urgent care is available on all plans.		
Emergency Services	All plans cover emergency services in the emergency department at the in-network level of benefits in the United States. All off-Marketplace only Small Group HMO plans include access to care for emergent conditions outside the U.S.		
Pharmacy	The Express Scripts® National Pharmacy Network includes most national and local pharmacies .		



Network Providers—PPO

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

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

Note: All off-Marketplace Small Group plans and national gold and silver on/off exchange PPO plans include access to care for emergent conditions outside the U.S.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	PPO NE	PPO National
Medical, Behavioral and Substance Use Disorder	<p>Community Health Options’ broad New England network includes providers across ME & NH as well as a limited number of key providers in MA & VT.</p> <p><i>For services outside of ME, NH, MA and VT, out-of-network coverage is available with higher cost sharing.*</i></p>	<p>Includes Community Health Options’ broad New England network, as well as in-network national coverage through the First Health® network.</p> <p><i>Out-of-network coverage is available with higher cost sharing.*</i></p>
<p><i>*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.</i></p>		
Telehealth	<p>If a provider offers telehealth services, routine in-network and out-of-network rates will apply.</p>	
Emergency Services	<p>All plans cover emergency services in the emergency department at the in-network level of benefits in the United States. All off-Marketplace only Small Group plans and all Individual on/off Exchange National Gold and Silver PPO plans include access to care for emergent conditions outside the U.S.</p>	
Pharmacy	<p>The Express Scripts® National Pharmacy Network includes most national and local pharmacies.</p>	



Network Providers

Finding the Care You Need

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

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

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

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

BEFORE YOUR PCP VISIT

- Review your Summary of Benefits & Coverage to confirm your cost share for a PCP visit.
- Be prepared to pay on the day of your appointment.
- Preventive care visits with in-network PCP/PED providers are available at zero cost share. Services covered are based on the recommendations listed at [healthcare.gov](https://www.healthcare.gov). Note: Tests and additional services provided during the visit may be subject to routine cost sharing.



Network Providers

More questions about where to go for care?

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

WHERE TO GO FOR CARE

Primary Care		
Healthcare Service	When & Why to Choose This Option	Typical Expense
<p>Primary Care Provider (PCP)/ Pediatrician (PED)</p> <p><i>The doctor, physician assistant or nurse practitioner you chose when your Community Health Options coverage began.</i></p> <p>Note: If you are on a tiered plan, make sure you select a preferred provider for reduced costs.</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>\$</p>
<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 a hospital emergency department.)</p>



Network Providers

More questions about where to go for care?

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

WHERE TO GO FOR CARE

Urgent Care		
Healthcare Service	When & Why to Choose This Option	Typical Expense
<p>Amwell® Urgent Care Telehealth Visits online or over the phone with a clinically licensed urgent care provider.</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>\$0</p> <p>No cost share for all non-HSA plans; and \$0 <u>after</u> deductible for HSA plans.</p>
<p>Urgent Care These are stand-alone, walk-in clinics. Click here for a list of in-network urgent care locations. Note: If you are on a tiered plan, make sure you select a preferred urgent care location for reduced costs.</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>\$\$</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 	<p>\$\$\$</p>



Preventive Care

Community Health Options has your back when it comes to preventive health and wellness. Many preventive healthcare services, including screenings, check-ups and counseling have no cost share. Unlike other carriers, Community Health Options does not require you to wait 366 calendar days between visits to see your provider for annual preventive wellness care and checkups. These annual visits reset based on the date your coverage begins, not the date of your last appointment. While it is best to schedule your yearly preventive services approximately 12 months apart to get maximum benefit, you have some flexibility with appointment dates and peace of mind knowing your care is on your schedule. Annual wellness visits based on your plan year include preventive wellness visits, mammograms, adolescent hearing screenings, low-dose CT scans for lung cancer screening, labs and immunizations.



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



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



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



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



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



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



Preventive Care

Diagnostic versus Preventive Services

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

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

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

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

- What is the test for?
- Why is this service needed?
- Are there any alternatives?
- What are the possible complications?
- Is there an in-network option for this service?

If you are in a tiered network plan and additional services or tests are recommended, be sure to check for an in-network provider. If you have questions about how services are covered, contact Member Services (855) 624-6463, Monday through Friday, 8:00 a.m. – 6:00 p.m. or [email](#) the team.



Preventive Care

Commonly Asked Preventive Services Questions

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

Visit [healthcare.gov](https://www.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](https://www.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](https://www.healthcare.gov) by clicking [here](#).
- Visit the Adult Preventive Services benefits by clicking [here](#).

**New guidelines may be published. The timing of no-cost coverage is applied to a future date.*

For example, a recommended service release date in March 2023 may not be covered as a preventive service until 2025.



Wellness Benefits

Wellness is our priority, which is why our benefits focus on easing access and affordability for the care you need. Set up your Member portal for easy access to these resources and services, as well as other important plan details and documents.

Primary Care

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

Telehealth for Provider Visits

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

Behavioral Health

Community Health Options is committed to prioritizing emotional well-being with physical health. The **first in-network, outpatient behavioral health visit for you or your dependents have no cost share** on non-HSA plans for in-person or online/telephonic visits. Outpatient behavioral health services are provided at preferred cost sharing on HMO tiered plans. Community Health Options will even cover a medical visit and a behavioral health visit on the same day, and we can facilitate same-day referrals. Telehealth psychiatry and counseling/therapy services are also available through Amwell.

Amwell Telehealth

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



Wellness Benefits

Chiropractic and Osteopathic Adjustment Coverage

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

Acupuncture

Select plans include the acupuncture benefit. Non-HSA plans have a copay for visits to in-network acupuncturists. In addition, Members are not required to meet a deductible before accessing acupuncture benefits and may receive reimbursement of up to \$50 per visit for out-of-network visits.*

Vision

Plans that offer adult and pediatric vision coverage include one eye exam every 12-month calendar year with deductible and coinsurance on adult exams, and on non-HSA plans, pediatric visits are with a copay. Pediatric coverage for glasses and contacts are included on all plans (every 24-month calendar period) with varying coinsurance, copayment or deductible requirements.

Oral Health

Community Health Options partners with Northeast Delta Dental® (NEDD) to provide dental coverage for pediatric Members in select plans. A special, low dental deductible applies and covered out-of-pocket dental expenses are applied to medical out-of-pocket expenses. See your plan documents or call Member Services at (855) 624-6463 for more information.

**Not available on catastrophic plans.*



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 just getting started, we'll be there every step of the way. We are committed to supporting you throughout your wellness journey.

Health Education

Our partners at Healthwise® provide 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. Members can access Healthwise materials in their Member portal.

Digital Wellness Platform and App

Community 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 and gamification—including daily text nudges and an opportunity to earn rewards, and health education all geared toward driving positive habit formation and behavior change. The holistic and personalized approach guarantees a path toward better health. Members with this program can access their account through the health and wellness tab in the Member portal, download the WellRight app, or log on to healthoptions.wellright.com.

Unlimited Personalized Health Coaching

Our Healthy Maine plans include access to unlimited personalized health coaching for Members age 18 years and older with no deductible and no cost through the WellRight platform. Trained health coaches can meet over the telephone or via email and can assist with the following:

- Personalized Nutrition
- Physical Activity
- Weight Management
- Financial Fitness
- Prenatal Wellness
- Heart Health
- Treatment for Tobacco Use
- Stress Management
- And More!

Treatment for Tobacco Use

Our Tobacco Cessation Program offers 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 at (855) 624-6463 to get started.

Care Management

Community Health Options' care managers are specially trained to help you with medical services you need and to assist you save money on prescribed medications. Programs are available to aid our Members through a broad spectrum of services. These include transitions of care such as hospital to home, disease management, chronic condition management, cancer care, maternity/postpartum care, and behavioral healthcare. Our Care Management team partners with a range of local agencies to offer community support.



Chronic Illness Support Program

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

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

BENEFITS INCLUDE

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

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 mail order 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

*Not available on catastrophic plans.



Pharmacy Management

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

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

Prescription Programs

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

Special Insulin Provision

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

ACA Preventive Drug Coverage

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

Low Copay Preferred Generic Medications (Tier 1)

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

HSA Plus Enhanced Preventive Drug Coverage

HSA Plus plans include a carefully curated list 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 and require Members to pay only the applicable coinsurance or copayment amounts. To view the H.S.A.-designated drugs, review the formulary in your Member portal or at healthoptions.org.

**Not available on catastrophic plans.*



Pharmacy Management

Pharmacy Benefit Manager

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



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

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



Pharmacy Management

Getting Started: Filling Prescriptions

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

Benefits of mail orders:

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

For more information, go to [Express Scripts](#) to set up your account. It's as easy as clicking on the **Register** button and following the prompts.

*Certain limitations apply.

Express Scripts Mobile App

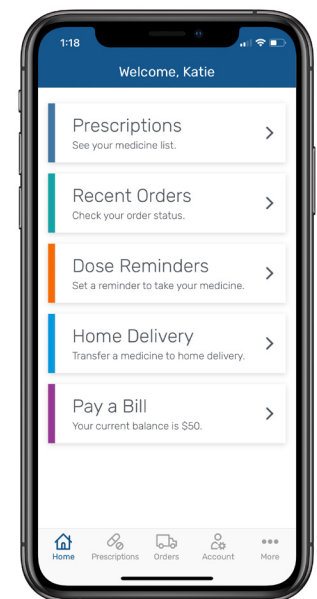
STAY ON TRACK WHILE YOU ARE ON THE GO

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

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

ACTIVATE YOUR EXPRESS SCRIPTS ONLINE PORTAL

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



Pharmacy Management

Specialty Pharmacy

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

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



Pharmacy Success Story

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



Medical and Care Management

Medical Management

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

Care Management

MANAGING SERIOUS ILLNESS OR INJURY

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

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

HOSPITAL READMISSION PREVENTION PROGRAM

With a **53% reduction** in readmission rate (2018–2022), we are working hard to help Members get well while reducing costs associated with readmission to the hospital. In-house specialists coordinate with Care Management to assist Members at high risk of readmission. Examples include partnering with home health agencies, community agency care teams and other local agencies.



Medical and Care Management

Care Management (continued)

SITE OF CARE PROGRAM

Our voluntary **Site of Care Program** has saved millions of dollars in healthcare costs for our Members by offering the ability to transition certain medications that need to be delivered intravenously (IV) and infusions to a preferred site of care, including a Member's own home. This program delivers a meaningful choice with **reduced out-of-pocket costs** and **increased quality of life**. In addition to these savings, Members will be offered a monetary incentive payment for select medications when receiving infusions from a preferred Site of Care provider.

SUBSTANCE USE DISORDER

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

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

Care Management Success Story

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



Member Services



Member Service Excellence

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

PROMISES DELIVERED

When we make a promise to do something, we keep that promise. We always have your back. We are committed to Members' satisfaction every day. In recent post-call surveys with our Members, we earned **100% satisfaction for courtesy and respect, 98% for receipt of information needed and 98% for the speed of answer.**

WE DON'T ISSUE HOMEWORK

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

MEMBER SURVEY RESULTS:

100% satisfaction for courtesy and respect

98% satisfaction for receipt of information needed

98% satisfaction for speed of answer

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



Frequently Asked Questions (FAQs)

When will I get my first invoice?

If you have enrolled in an individual policy, we will mail an invoice to you around the tenth (10th) business day of every month. Invoices are payable by the first (1st) of the following month. If you are on a group policy, contact your employer for information on your premium payment.

Individual policy Members can make a payment by:

1. Logging into your Member portal and clicking the **Pay my premium** button.
2. Calling the automated payment line at (844) 722-6243.
 - For debit or credit card payments, please have your Member ID, debit or credit card account number, security code and expiration date ready.
 - For payments by check, please have your Member ID, bank routing number and account number ready.
3. Mailing a check to **Community Health Options, PO Box 986529, Boston, MA 02298-6529**. Please include your invoice coupon and policy number on the check or money order.

What is a Preferred Provider Organization (PPO)?

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

- PPOs require you to select an in-network primary care provider (PCP) who has a contracted agreement with Community Health Options. In-network means we have a contract that states these providers will accept payment on the contracted dollar amount instead of their usual charges. Network providers cannot bill you for the difference between their charged rate and their contracted rate.
- PPOs **do not** require you to get a PCP referral for specialist care. However, many specialists DO require referrals, even if our plans do not.
- If you choose out-of-network services and providers, these costs are applied to a separate deductible and out-of-pocket maximum than your in-network services and providers. Costs are paid at the “usual and customary” rate. If the costs exceed this amount, you may be billed for the difference.

What is a Health Maintenance Organization (HMO)?

Both HMO and PPO plans require that you select a primary care provider (PCP) from our network, but HMO plans generally come with lower premiums and have fewer provider choices. With an HMO:

- Your PCP coordinates in-network care.
- You have no out-of-network coverage.



Frequently Asked Questions (FAQs)

What is an HMO tiered plan?

HMO tiered 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)?

HSA stands for a health savings account which is compatible with a particular type of high-deductible health plan. These plans require a special type of bank account and 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 who 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 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. If you have questions, contact Member Services at (855) 624-6463.



Frequently Asked Questions (FAQs)

Which life events could affect my health insurance coverage?

The following circumstances may trigger a Special Enrollment Period when you can change your coverage:

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

Other Qualifying Changes:

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

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

- **Our in-network providers** have signed a contract with us to accept payment on a 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, Community 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.

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

All of our off-Marketplace only Small Group plans offer access to care for emergent conditions when you travel out of the country. Individual on/off Exchange National Gold and Silver PPO plans also include out-of-country emergency coverage. If you plan to travel outside the U.S., including Canada, please check your plan benefits and consider supplemental travel insurance.



Frequently Asked Questions (FAQs)

What is a prescription drug formulary?

The formulary is a list of covered prescription medicines deemed 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 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.

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.

When do I have to pay copayments (copays)?

A copayment is a fixed amount you pay for a covered healthcare service, usually when 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. Generally, copayments do not count toward your deductible. Copayments 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 uploaded to your Member portal upon the completed processing of a medical claim. An EOB will explain the Community Health Options' payment and your financial responsibility according 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, 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.



Frequently Asked Questions (FAQs)

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 Inc.[®], 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.

What does merged markets mean for me?

The Maine Bureau of Insurance announced the merger of the Individual and Small Group markets in 2023, seeking to provide more stable pricing for both markets over time by pooling the risks of both markets. As a result, Individuals and Small Groups have the opportunity to purchase any plan in the merged market. Members and groups should continue to purchase on-exchange plans to use on-exchange cost share reductions and tax credits.

More questions?

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





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

At Community Health Options, you 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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