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

Member Guide **2026**

COMMUNITY Health Options®

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Community Health Options Overview

Community Health Options is the only Maine-based, nonprofit, Member-led health insurer and plan administrator providing comprehensive health plan options for individuals, families and businesses.

You're the reason we do what we do, so you can have the health plan coverage and wellness tools you deserve—and can actually use. Our network of more than 48,000 providers is the most robust you'll find in Maine, including clinicians, hospitals and pharmacies across the state and into New Hampshire, Vermont and Massachusetts. The network comprises all hospitals in Maine and most in New Hampshire, along with access to many Centers of Excellence in New England. If you live outside of Maine or New Hampshire part-time, like to travel or have a child away at college, our national plans include coverage for care across the United States.

When you need help, we're here for you. Our Maine-based Member Services team is ready to help you get the most from your plan benefits and answer any questions. It's health insurance that feels different—because it's health insurance the way it should be.

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

Overview of 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 the best possible care at the best prices, and our team is ready to help you at every step of the way.

Our plans include these benefits:

- All of the **preventive care benefits** required by the Affordable Care Act and the State of Maine with no cost share at in-network providers.
- Our **Chronic Illness Support Program** (CISP) on non-HSA plans makes it easier to manage and pay for the treatment of select chronic conditions.*
- **No costs for the first in-network primary care and behavioral health care** visits during a plan year 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 at the same cost as traditional primary care, and with even lower copays on select plans.
- Access to **Amwell®** $0 urgent care telehealth visits.
- All non-HSA plans offer a site of service copay benefit at specified locations for labs and X-rays, as well as advanced imaging on select plans. If you have an HSA plan, you'll pay a copay once you meet your deductible.
- $0 cost **tobacco use treatment** including over-the-counter nicotine replacement therapy products such as nicotine patches, gum, lozenges and certain medications listed on our drug formulary.
- HSA Plus plans include prescription coverage for select drugs without a deductible.
- $0 cost digital wellness platform and mobile app on select plans.
- Our **Infusion Site of Care Program** offering high-quality, lower-cost services and incentives for select infusion medications.
- Our prescription programs help Members save on medications, coordinate refills for multiple prescriptions, and reduce out-of-pocket expenses with tools like Price Assure, Medication Synchronization Program, and ScriptSaver.
- **NEW!** Save on services by selecting a Northern Light provider on our North Star plans.

**Not available on Catastrophic plans.*

Overview of Benefits

SAVE WITH A COPAY AND NO DEDUCTIBLE WHEN USING SELECT PROVIDERS/SERVICES:

Excludes HSA & Catastrophic plans

- **$0 or $5 copays** on 30-day Tier 1 preferred generic medications
- **$25 copay** for labs at **specified lab locations**
- **$75 copay** for **specified X-ray locations**
- **Copay** on select plans for advanced imaging at **specified imaging locations**
- **Copays** on all plans for annual pediatric vision exams, and on select plans for adult vision exams
- **Copays** for physical, occupational and speech therapy visits as well as chiropractic and osteopathic adjustments
- **Copays** on in-network acupuncturists on select plans
- **Lower copays** on tiered plans when using a preferred provider

Finding Important Information About Your Plan

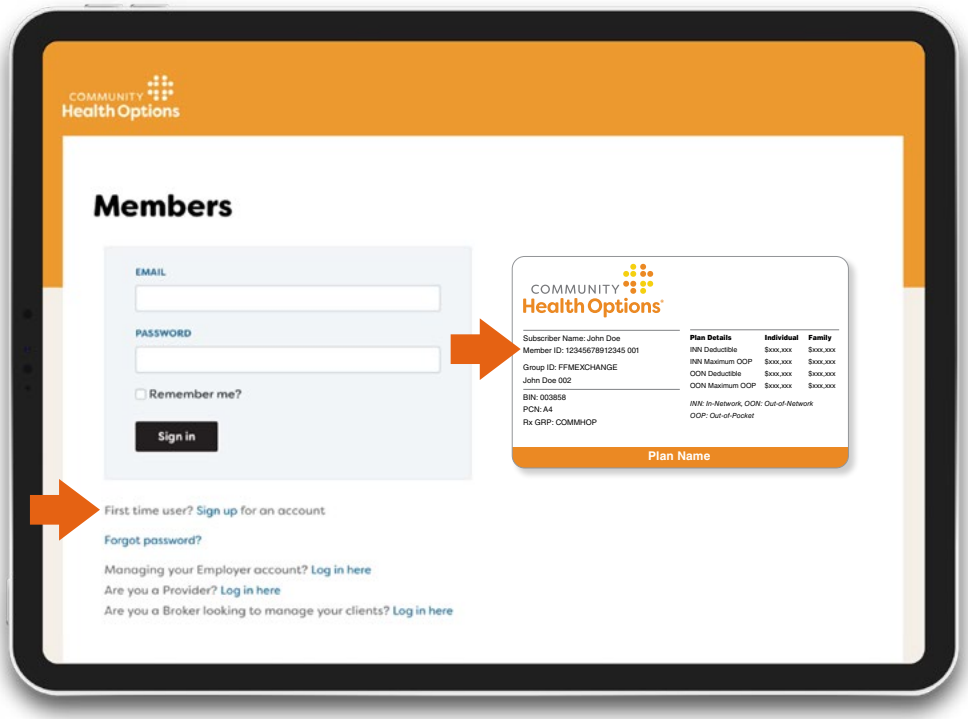
When you enrolled, you received a welcome packet with a Member ID card and instructions to set up your online portal. The Member portal provides access to plan benefits, claims, paperless delivery, primary care provider (PCP)/pediatrician (PED) selection and more. You'll also find a form that gives a family member or caregiver access to your protected health information. Simply download the Protected Health Information (PHI) disclosure form in the "Forms & Resources" tab in your portal, fill it out and send it to us via mail or email.

Getting Started Online: Your Portal

The portal has everything you need to get started with your new benefits plan. Setting up your **secure, personal 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:

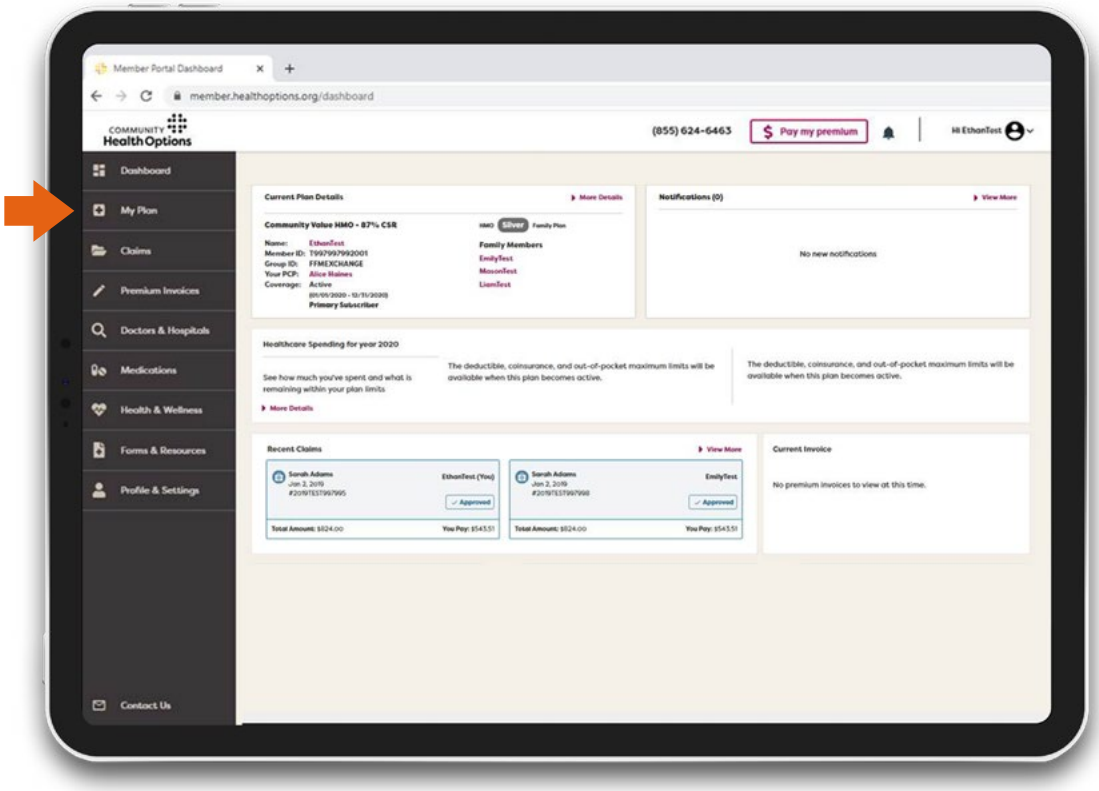
- Go to **healthoptions.org**.
- Click on **Sign In** at the far right upper corner of the screen.
- Select **Member Login**.
- Click on **First Time User? Sign up for an account**.
- At the next screen, enter your Member ID number, last name and date of birth.



Get to Know Your Portal

Once you set up your account, your **portal** shows your personal dashboard. From there, you can click on the menu to the left to find the information 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 Portal

More ways to use your portal to manage your benefits:

FIND A PROVIDER

You have several options through your portal to find the health care that's right for you. To get started, click on **Providers & Hospitals** to open the provider search tool.

FIND ESTIMATES FOR SERVICES

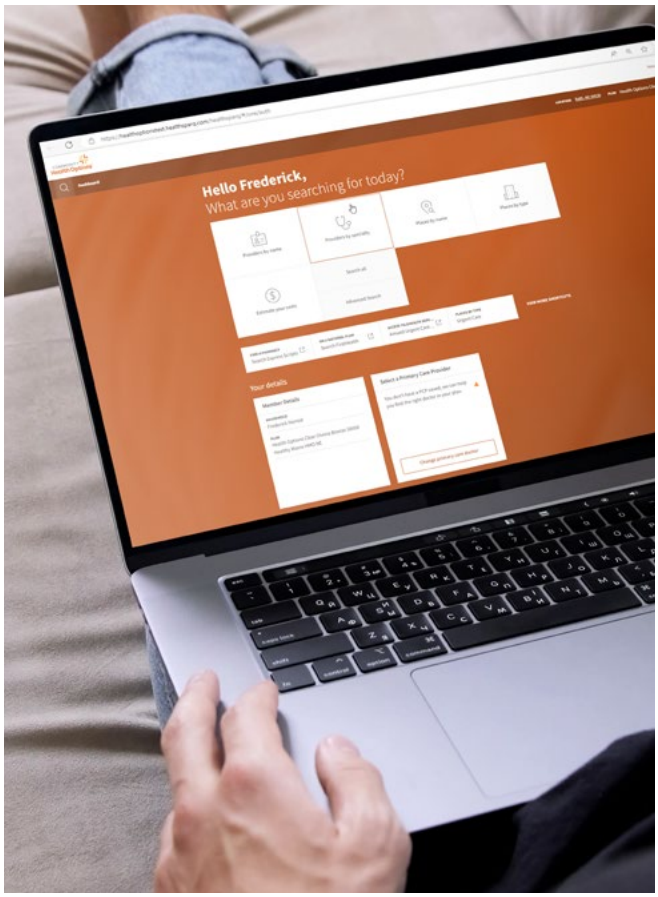
Use the cost estimator tool to understand and compare the costs of products and planned services. On your dashboard, click **Estimate My Costs** to learn more. This will present estimated costs and a customized cost share experience based on your plan.

FIND MEDICATIONS

Find and confirm medications covered by your plan and set up delivery for most maintenance prescriptions right to your door—often with better savings than most pharmacies. Click on **Medications** to get started.

PAPERLESS DELIVERY

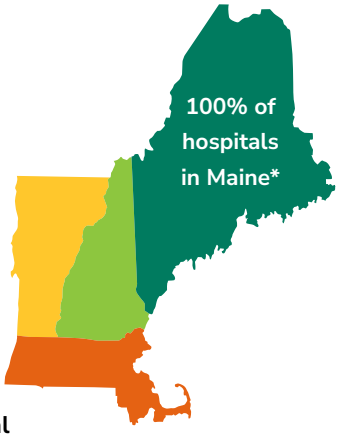
Many communications are sent electronically to your portal, including Prior Approval letters, Explanation of Benefits and invoices. It's simple, secure and convenient. Plus, you can check your claims, see updates and more. **If you prefer to receive paper documentation, contact Member Services** at (855) 624-6463 from 8 a.m. to 5 p.m., Monday through Friday, or **email the team using our contact form**.



Navigating Your Network

Community Health Options offers the most robust network in Maine, which also includes providers in New Hampshire and many Centers of Excellence in New England.

Our network comprises 100% of the hospitals in Maine, most in New Hampshire and the premier institutions outlined below:*



- **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.*

Our national plans feature our national wrap network, offering coverage across the country.

Selecting a Provider

When planning a visit to the doctor, it is important to understand your plan type and plan network. Your plan name is listed on your Member ID card.

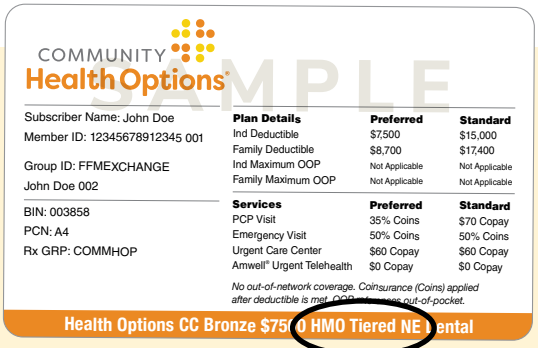
1 FIND YOUR PLAN TYPE

Look at your Member ID card to find your plan type, **HMO** or **PPO**. HMO plans provide access to our robust network with no out-of-network coverage, while PPO plans provide out-of-network coverage with higher cost sharing.

2 FIND YOUR NETWORK TYPE

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

New England: Includes the Community Health Options network with more than 48,000 clinicians, hospitals, and pharmacies in **Maine, New Hampshire, Vermont and Massachusetts**. All plans have access to this network.



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

Tiered NE: Includes the Community Health Options network and offers **reduced copays or coinsurance when you choose a preferred provider**.

National: Includes the Community Health Options **network and in-network access to providers across the country**.

Network Providers

All plans offer in-network coverage through our Community Health Options network, covering Maine, New Hampshire, and many Centers of Excellence in New England.

HMO PLANS

- HMO Tiered plans offer access to high-quality preferred providers at lower costs.
- HMO National plans provide national in-network coverage through our national wrap network, which can be accessed from the Provider Directory.

PPO PLANS

- All PPO plans include out-of-network coverage at a higher cost.
- PPO National plans also feature national in-network coverage.

OVERVIEW OF OUR NETWORK OPTIONS

SERVICE	HMO TIERED NE	HMO NATIONAL	PPO NE	PPO NATIONAL
Robust ME and NH coverage, including 100% of hospitals in ME and most in NH	✓	✓	✓	✓
Many Centers of Excellence in New England	✓	✓	✓	✓
In-network national coverage through our national wrap network	✗	✓	✗	✓
Lower copays or coinsurance at preferred providers**	✓	✗	✗	✗
Out-of-network coverage*	✗	✗	✓	✓
Virtual care for urgent care, PCP and behavioral health visits	✓	✓	✓	✓
Express Scripts® retail pharmacy and mail order	✓	✓	✓	✓

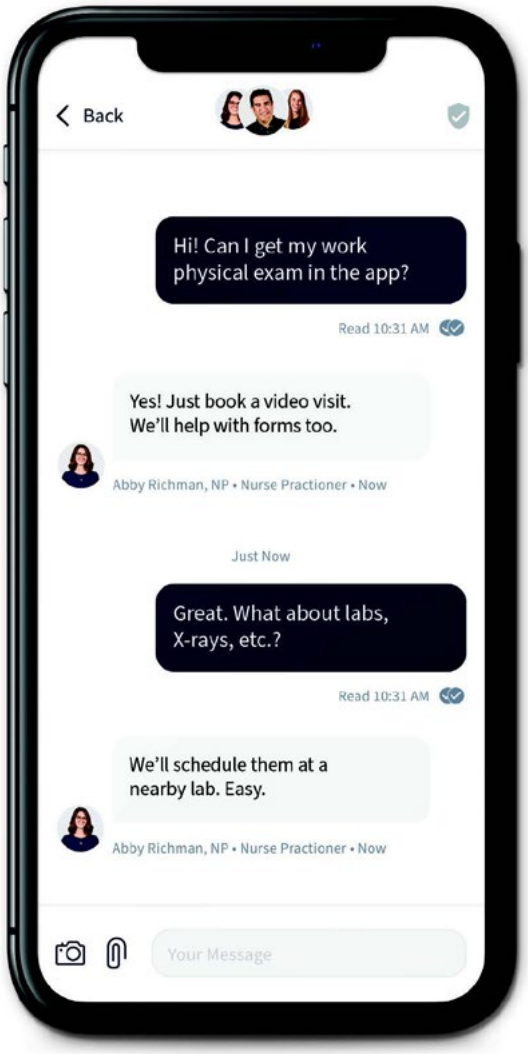
✓ = Included in Network
✗ = Not included in Network

All Small Group plans and Individual national plans include out-of-country emergency coverage. Please see plan docs for more information.

Network Providers

fireflyhealth

Virtual Primary Care with Firefly Health



How does this help you?

PRIMARY CARE. ANYTIME, ANYWHERE.

No more long waits to get into a primary care provider or wasted time on the phone trying to make an appointment. Get high-quality, personalized primary care right in your pocket, with anytime access to your care team, wherever you are.

PERSONAL CARE TEAM

When Members 18 years and older choose Firefly primary care, they get their own care team with a physician, nurse practitioner, health guide, and behavioral health specialist.

CARE THAT'S ON YOUR SCHEDULE

You can talk to your team via chat or video.

FIREFLY NEARBY

Your Firefly care team can deliver most care safely and virtually. When you do need in-person care (such as a physical exam or a swab), your team will guide you to Firefly Nearby providers in your area. These may be urgent care clinics, retail or convenient care clinics, or even providers that come into your home.

Access to primary care just got a whole lot easier. Visit fireflyhealth.com/with/cho to learn more.

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 the provider directory to be sure the PCP/PED has a tiered designation.
- Check how long it will take to get 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 **fireflyhealth.com/with/cho**.

BEFORE YOUR PCP VISIT

- Confirm how much you'll pay (in your Summary of Benefits & Coverage in your portal).
- Check to see if you need to pay at the appointment.
- Bring a list of medications and your questions. Importantly, you'll pay nothing for a preventive visit with coverage based on **services listed at healthcare.gov**. *Note: You may have to pay for tests and additional services. Please view your plan documents or visit your portal for more information.*

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 they meet their deductible.

You can find site-of-service locations by visiting Providers & Hospitals in your portal or clicking the links below.

- **$25 copay on labs at specified locations.**
- **$75 copay on X-rays at specified locations.**
- **$250 and $350 copay on select plans, for advanced imaging at specified imaging locations.**

On select plans, you'll also save when you visit specified urgent care locations or use Firefly Health for primary care services.*

**Members on Silver $5000 HMO Tiered NE and Bronze $7500 HMO Tiered plans pay lower copays for services though Firefly Health primary care and for care received at specified urgent care locations. View your plan details for more information.*

WHERE TO GO FOR CARE: PRIMARY CARE

HEALTH CARE 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 wellness 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 health care 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 vary but will generally be lower than in a hospital emergency department.

Network Providers

WHERE TO GO FOR CARE: URGENT CARE

HEALTH CARE 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
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 health care services at no cost, including screenings, checkups and counseling to avoid medical conditions. It's usually best to schedule your annual checkup about every 12 months for the maximum benefit, but you don't have to wait 365 calendar days to see your provider for wellness care and checkups. Your benefit resets based on the first day your coverage begins, so you have peace of mind knowing you can make appointments on your schedule. Refer to your plan documents for details on all covered preventive services.

Adult and pediatric preventive care benefits, outlined by state and federal laws, covered at no cost when you visit in-network providers.

Yearly flu vaccinations for adults and children at in-network doctors or pharmacies.

COVID-19 vaccinations or provider-administered COVID-19 testing/screening at no cost to you.

Preventive screenings that can find diseases or medical conditions before you have any symptoms, so you get an early diagnosis. These screenings exclude tests or services to monitor or manage a condition or disease you already have.

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

Preventive counseling when your provider finds you're at risk for a disease or medical condition. This counseling can give you the information you need about the risk and help you manage your health.

Preventive Care

Diagnostic versus Preventive Services

Diagnostic services, subject to routine cost sharing, include a range of tests or procedures your provider uses to figure out what's causing **symptoms, or** to diagnose or monitor a medical condition. These could include lab tests, imaging, cardiovascular tests and other procedures designed to find an illness and set a course for treatment.

Preventive services include tests often suggested by your provider when you have a routine physical or checkup, when you're symptom-free and have no reason to be concerned. You can get many screenings for yourself and your family with no out-of-pocket cost. Check **healthcare.gov to find out which preventive tests are included**, as outlined by the Affordable Care Act (ACA).

If your provider recommends a specific service, it's helpful to ask:

- What is this test for?
- Why do I need this service?
- Does the test have risks?
- Are there alternatives to this procedure?
- Will you please refer me to an **in-network** or Site of Service location?

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 children and adults, along with specific services for 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 as outlined by the Health Resources and Services Administration.

Which immunizations are covered as a preventive service?

Community Health Options covers routine immunizations listed on the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices website for children, adolescents and adults. This includes:

- Most childhood (age 18 or younger) vaccinations, including HPV for boys and girls. View **child and adolescent routine immunizations** (age 18 or younger).
- **Common adult routine immunizations**.

Are lab tests covered as a preventive service?

Many lab tests, like a complete blood count (CBC), Lyme disease, Vitamin D or thyroid test are considered diagnostic and subject to cost sharing. Note that you can often save money by visiting specific labs. However, screening tests like cholesterol and blood sugar tests are covered at no cost to you, based on your age and risk factors, as long as those tests aren't monitoring a condition you already have. You can find **preventive lab tests at healthcare.gov** or by visiting the specific pages below:

- View the **Preventive Care Benefits for women**.
- View the **Preventive Care Benefits for children**.
- View the **Preventive Care Benefits for adults**.

**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 2026 may not be covered as a preventive service until 2028.*

Wellness Benefits

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

Primary Care and Behavioral Health

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

Virtual Care

A provider visit can be just a click away, and virtual care service makes it easy for you to schedule appointments and access urgent care, all from the comfort of your home.

- If your provider offers telehealth services, you'll have the same plan coverage as in-network or out-of-network provider office visits.
- Members 18 years and older can choose virtual primary care through **Firefly Health**, with a virtual primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide, who will refer you to local in-person providers when necessary. To learn more, visit **Firefly Health**. Appointments will have the same plan coverage as in-network primary care office visits. Our Health Options Clear Choice $5000 HMO Tiered NE and Health Options Clear Choice $7500 HMO Tiered NE plans have a site-of-service copay of $25 for Firefly Health primary care provider visits.
- All plans include telehealth for urgent care, psychiatry and counseling/therapy through **Amwell®**. One-time and continued behavioral health care visits can be easily managed through the Amwell patient portal. Urgent care telehealth is available night or day, providing access to treatment whenever you need it **at $0 cost**.

Wellness Benefits

Chiropractic and Osteopathic Adjustment Coverage

All plans include coverage for chiropractic and osteopathic adjustments. You'll find detailed information in your plan documents located in your portal.

Acupuncture

Our Platinum, Gold and National Silver plans have coverage for acupuncture services with a copay for in-network providers and up to $50 reimbursement for out-of-network providers. HSA Members with this benefit can get in and out-of-network reimbursement up to $50 per visit with no deductible. You'll find detailed information in your plan documents located in your portal.

Vision

All plans offer adult and pediatric vision coverage including one eye exam every 12-month calendar year. On non-HSA plans, pediatric visits have a copay, and on certain plans, adult visits also have a copay. All plans include pediatric coverage for glasses and contacts (every 24-month calendar period) with varying coinsurance, copayment and deductible requirements.

Oral Health

Community Health Options partners with Northeast Delta Dental® to provide dental coverage for pediatric 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 located in your portal.

Wellness Programs & Tools

Our programs and tools can 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.

Wellness Platform and App

On select plans we partner with WellRight® to provide a digital wellness 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 risk assessment. You can access your account through the Health and Wellness tab in your portal, by downloading the WellRight app or logging 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.

Treatment for Tobacco Use

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 is available at $0 out of pocket.* Our care managers are available to support you along your journey to becoming tobacco free. Call Member Services at (855) 624-6463 to get started.

Care Management

Our Maine-based care teams are specially trained to help with the medical services you need and to help you save money on prescribed medications. They also provide a range of services, including transitions of care such as hospital to home, disease management, chronic condition management, cancer care, pregnancy/postpartum and behavioral health care. Additionally, our Care Managers partner with local agencies to access community support.

**Limited to two (2) ninety (90) day treatment cycles.*

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 high blood pressure (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

CONDITION	OFFICE VISITS WITH DIAGNOSIS CODE FOR	ALSO COVERED
Asthma	• Primary care, pulmonologist, allergist for routine management • Palliative care to discuss condition treatment • Immunotherapy for allergen sensitization	• Inhaler adjuncts (e.g., holding chamber/spacer) through mail order • Pulmonary function tests • Allergy sensitivity testing • Asthma education • Targeted laboratory tests for routine management
Coronary Artery Disease (CAD)	• Primary care, cardiologist for routine management • Palliative care to discuss condition treatment	• Electrocardiogram (ECG) • Nutritional counseling, up to 12 visits per year • Cardiac rehabilitation and associated exercise programs are covered at 50% cost share reduction • Targeted laboratory tests for routine management
Chronic Obstructive Pulmonary Disease (COPD)	• Primary care, pulmonologist for routine management • Palliative care to discuss condition treatment	• 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 routine management **Note: Oxygen delivery and supplies are subject to routine coverage.**
Diabetes	• Primary care, endocrinologist, podiatrist, optometrist/ophthalmologist for routine management • Palliative care to discuss condition treatment	• 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: Except FreeStyle Libre, continuous glucose monitors, insulin pumps, and associated supplies are subject to routine coverage.**
Hypertension	• Primary care, cardiologist and nephrologist for consultation and routine management • Palliative care to discuss condition treatment	• 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.

Pharmacy Management

Our in-house pharmacists work to develop a competitive and cost-effective prescription drug formulary in partnership with Express Scripts®, our pharmacy benefit manager. Notably, our Pharmacy team has found that 90% of the prescriptions filled for our Members were generics—saving you money and making it easier to stay on schedule. To get started and view the drug formulary, visit your portal and click on the "Medications" tab.

Prescription Programs

- **Price Assure** guarantees the lowest possible cost for generic medications at in-network pharmacies that also accept GoodRx. By using your Member ID card, you can be sure that your cost applies to your maximum out-of-pocket expense.
- Through the **Medication Synchronization Program**, our Pharmacy team works directly with you to coordinate refills when prescribed three or more maintenance medications. That way, you can pick up everything at your local pharmacy at once.
- With **ScriptSaver**, our Pharmacy team works with you, your providers and the pharmacy to lower out-of-pocket costs, including finding manufacturers' coupons. The program has saved Members more than $680,000 since it began.

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

While we cover many medications, prior authorization, step therapy, and limits may apply. **Read more here**.

ACA Preventive Drug Coverage

Under the Affordable Care Act (ACA), pharmacy benefits cover many preventive care drugs and products at no cost to you provided that ACA preventive care requirements are met. This means there is no cost share (deductible, copayment or coinsurance). These drugs will be marked with ACA on the formulary. Plus, you'll pay no more than **$35 for a 30-day supply of all formulary covered insulins**. To view the ACA-included medications, visit your portal or view the **formulary**.

Low Copay Preferred Generic Medications (Tier 1)

Tier 1 preferred generic prescription drugs cost $0 or a $5 copay for a 30-day supply on all non-HSA plans. Members can save even more through Express Scripts' mail-order home delivery, which offers a 90-day supply for the cost of two 30-day copays.

HSA Plus Enhanced Preventive Drug Coverage

HSA Plus plans include a carefully curated list of medications to help prevent the development of and reduce the risk of complications from chronic conditions and illnesses. You'll have a copay or coinsurance without having to meet a deductible for these prescription drugs, which are marked HSA+ in the formulary. To view the HSA+ medications, visit your portal.

NOTE: If your prescription drug is not available on our formulary, reach out to Member Services for assistance connecting with our Pharmacy team.

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

Pharmacy Management

Getting Started: Filling Prescriptions

We want you to benefit from the best prices for prescriptions and over-the-counter medicines ordered by a provider. Our pharmacy network gives you access to retail pharmacies across the country and home delivery by mail order through Express Scripts®.

Mail order savings:

- Order most prescribed maintenance medications for three months at a time through the ESI Extended Payment Program (EPP), which allows you to divide the cost over three payments.*
- Pay only two 30-day copays when you order a 90-day supply.*
- Order Chronic Illness Support Program qualified medications through mail order at the CISP discount.
- 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.*

SET UP YOUR EXPRESS SCRIPTS ONLINE PORTAL

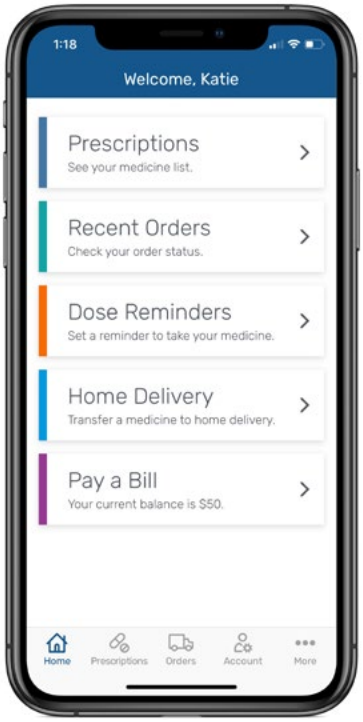
- Express Scripts, our pharmacy benefit manager, provides help with prescription-related information and services through its own website.
- Register with Express Scripts by going to the portal's Medications section and clicking **Get started / Log in**.

Express Scripts Mobile App

STAY ON TRACK WHILE YOU ARE ON THE GO

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

Just search for "Express Scripts" and download the app from your app store. Log in with your username and password. First-time visitors must register using your Member ID number or Social Security number. 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 help you with medications for complex, chronic or rare conditions that require special handling or monitoring.

Benefits include:

- Medications mailed directly to your home.
- Pharmacists, nurses and other clinicians who support you every step of the way
- Support to ensure your benefits are covered by your plan and that you have the right approvals
- Help to find and use manufacturer and community financial assistance programs to cover the expense of specialty medications
- Learn more from **Accredo** or call (877) 895-9697.

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 health care professionals who work together to remove barriers, making it easier for you to obtain medications and durable medical equipment. These specialists also help to connect you with providers to assist with communication and education.

Our Care Team

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, transplants, and more. 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 ensure a seamless transition.
- Members identified with high health risks have access to complex care management resources.

HOSPITAL READMISSION PREVENTION PROGRAM

If you're admitted to the hospital, Community Health Options will help you stay at home and fully recover after you're discharged. Specifically, our in-house specialists work with our care team to help those at a high risk of being readmitted to the hospital to ensure they have access to the resources they need for recovery. That includes partnering with home health agencies, community agency care teams and other local organizations.

Medical and Care Management

Our Care Team (continued)

INFUSION SITE OF CARE PROGRAM

If you need intravenous (IV) medications or infusions, you can save money through our voluntary **Infusion Site of Care Program**, which has saved millions of dollars in treatment costs for Members. This program offers reduced out-of-pocket costs and the opportunity to get treatment at a preferred site of care, which may even be your home. In addition to these savings, you'll be eligible for a monetary incentive payment for select medications when getting 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. This includes support post-discharge from an inpatient behavioral health or substance use facility. Our team will work to help schedule **high-quality, cost-effective and convenient in-network care** to keep you from the financial and emotional stress of readmission.

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

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 York 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, 98% 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.

**2024 post-call survey results*

MEMBER SURVEY RESULTS:

99% satisfaction for courtesy and respect

98% 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 Maine Community Health Options eight or nine 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."

Frequently Asked Questions

When will I get my first invoice?

If you have enrolled in an individual policy, we will mail your first invoice to you around the tenth business day of the month, and subsequent invoices will be sent electronically each month thereafter on the same schedule. Invoices are payable by the first 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. You can also set up auto pay here.
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)?

HMO and PPO plans both 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

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.

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 health care 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 health care 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

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 Community Health Options or the First Health® network 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.

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 Individual National Gold and Silver PPO plans, and all Small Group plans include coverage to care for emergent conditions outside the country. If you plan to travel outside the U.S., including Canada, please check your plan benefits and consider supplemental travel insurance.

Frequently Asked Questions

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. **Download our prescription Drug Formulary**.

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

What 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.

What is a copayment (copay)?

A copayment is a fixed amount that you pay for a covered health care 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. 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, 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

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 on our website under our Knowledge Hub.

MORE QUESTIONS?

Call Member Services with your questions at (855) 624-6463, from 8 a.m. to 5 p.m., Monday through Friday, or email the team using our contact form.

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

Our team of Maine-based Member Services Associates earns high marks for answering questions with courtesy, respect and accuracy of information. Give them a call with your questions at (855) 624-6463, from 8 a.m. to 5 p.m., Monday through Friday.

COMMUNITY Health Options®

INDSG20250801

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.