Community Reliant HSA

MEMBER BENEFIT AGREEMENT

If cost-share reduction (CSR) is applied to your policy through the Marketplace, this plan is not qualified for HSA contributions, because the cost sharing reductions do not meet IRS standards. Furthermore, we recommend that you contact your tax adviser for further information. If your plan is subject to CSR, it will be clearly identified on your *Schedule of Benefits*.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Community Health Options (Health Options). If you have a Medicare supplement policy or major medical policy, this coverage may be more than you need. For information, call the Bureau of Insurance at 1-800-300-5000.

Renewal

Unless your coverage under the Plan from Health Options terminates, when you pay your Premium charges, your coverage renews for the period covered by the Premium. Your Plan will automatically terminate on December 31, 2016; however, if you continue to pay your premium and take no action to change your existing policy, your Health Options coverage will be renewed for the following calendar year. Your Premium may change at the beginning of the new Plan Year, subject to approval by the Bureau of Insurance. When a change in your Premium occurs, you will receive written notification from us, advising you of the new Premium and the effective date of the change. We will give you at least 60 days' notice of a Premium increase. The change in your Premium will appear in your next bill after the effective date of the change.

10-Day Agreement Review

This *Member Benefit Agreement*, the *Schedule of Benefits*, any Riders, and your *Application* (together, the "Agreement") make up your contract and complete coverage with Health Options for Benefits under the Plan. This Agreement replaces any previous health coverage agreement with Health Options you may have received.

If you decide not to accept this Agreement, send a signed cancellation form within 10 days of your effective date to:

Community Health Options
Attn: Enrollment and Eligibility
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243

Please check "10-Day Agreement Review Cancellation." We will then refund any Premium charges you have paid us for the Agreement. If you return this Agreement under this provision, we will refund any Premium payment for the Agreement, but Health Options reserves the right to recoup costs for any claims incurred during this 10-day period.

No Pediatric Dental Benefits

This Agreement and the Plan do not provide Benefits for pediatric dental services. Benefits for pediatric dental services must be purchased from another source that offers such benefits.

Contacting Health Options

You may contact Health Options Member Services at:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Toll-free number: 1-855-624-6463 (TTY/TDD: 711)
Internet: www.healthoptions.org

Deaf and hard-of-hearing Members may communicate with Health Options Member Services by calling 711 and providing Health Options' toll-free number 1-855-624-6463. A specially trained operator will help you communicate with Health Options Member Services.

EFFECTIVE DATE 01/01/2017

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at Compliance@healthoptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-624-6463 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-624-6463 (TTY/TDD: 711)	**Arabic** ملحوظة: إذا كنت تتحدث اللغة، انكر المساعدة خدمات فإن بالمجان لك تتوافر اللغوية. برقم اتصل 1-855-624-6463 رقم والبكم: TTY/TDD 711. هالصم
Cambodian, Mon-Khmer ប្រយ័ត្ន៖ បើសិនអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែក ភាសាមិនគិតថ្លៃ គឺមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព 1-855-624-6463 (TTY/TDD: 711)។	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-624-6463 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-624-6463 (TTY/TDD: 711).	**Thai** ียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-624-6463 (TTY/TDD: 711).	**Japanese** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-624-6463（TTY/TDD: 711）まで、お電話にてご連絡ください。

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1. INTRODUCTION

A. Introduction to the Agreement

Thank you for choosing Community Health Options ("Health Options") for your health insurance Plan (the "Plan"). This Agreement is the legal document that defines the relationship between Members and Health Options. It describes the Benefits, limitations, conditions and exclusions, and contains other important information relevant to Members enrolled in the Plan. **Please read this Agreement very carefully.**

Health Options agrees to cover and arrange for health care services to enrolled Members in accordance with this Agreement. As an enrolled Member under the Plan, you agree to all the terms of this Agreement.

For specific Benefit details, including any Member Out-of-Pocket Costs, please refer to the *Schedule of Benefits* for the Plan.

Under the Plan, a Member's health care is mainly provided or arranged through Health Options' network of Primary Care Providers (PCPs), Specialist Providers, and other Providers. The Plan provides Benefits for the health care services described in this Agreement and the *Schedule of Benefits*.

Health Options also provides Members with a *Member Handbook*, which is a separate document and not part of this Agreement. The *Member Handbook* provides Members with helpful information and answers common questions about Health Options' services.

You can access your Member materials electronically by downloading them directly from your portal at www.healthoptions.org or you may contact Member Services to request electronic or paper copies. If you have any special cultural needs or require translation services please contact Member Services at 855-624-6463.

B. About Community Health Options

Health Options is a Consumer Operated and Oriented Plan ("CO-OP"). The U.S. Centers for Medicare and Medicaid Services has established guidelines for CO-OPs. Health Options is a private, nonprofit entity governed by a Board of Directors made up mostly of Members. This representative Board gives Members like you a strong voice in the governance and development of Health Options.

Our Mission:

To partner locally with Members, businesses and health professionals to provide affordable, high-quality benefits that promote health and wellbeing.

Our Values:

Community Health Options believes that:

- *Every person is entitled to courtesy and respect.*
- *A trustworthy organization demonstrates honesty, integrity, independence, and consistency in policy and action.*
- *Discipline, focus, courage, and humility enable us to be open to learning from the challenges that confront us.*
- *It is important to embrace change and see positive potential in disruptive innovation.*
- *Spontaneity, balance, thoughtfulness, and curiosity are essential.*

Our Vision:

To be a leader in transforming and improving individual and community health and positively affecting the local economy.

C. How this Agreement Works

1. Generally

   This document explains:

   - Which health care services are Covered Services;
   - What is excluded from coverage under the Agreement;
   - How to obtain Covered Services and Prior Approval, if necessary;
   - Prescription drug benefits; and
   - Other information about your relationship with Health Options.

   Your Out-of-Pocket Costs, that is, costs you must pay, are detailed in the *Schedule of Benefits.*

2. Defined Words

At the end of this Agreement, you will find a Glossary of defined words used in this Agreement. Other defined words also appear elsewhere in this Agreement. These defined words begin with capital letters. It is important that you understand what the defined words mean.

When this Agreement uses the words "we," "us," and "our," this means Health Options and its designated affiliates. When this Agreement uses the words "you" and "your," this means the Subscriber and all Members covered under this Agreement.

Unless otherwise clearly noted, lengths of time expressed in terms of days in this Agreement shall mean calendar days.

3. *Schedule of Benefits*

The *Schedule of Benefits* lists your expected Out-of-Pocket Costs for Benefits and Prescription Drugs covered under the Plan.

4. Plan Providers and the Provider Directory

The Provider Directory lists the Primary Care Providers (PCPs), Specialists, Hospitals, and other Plan Providers who have contracts with Health Options to provide Covered Services to our Members. The Provider Directory is also a place to go for information on Plan Providers, including contact information and office hours. The regularly updated Provider Directory is available online at https://www.healthoptions.org/Search-provider. If you do not have online access, you may obtain a printed copy by calling Member Services. Members are encouraged to use Plan Providers. Your Out-of-Pocket Costs are typically lower when you receive Covered Services from a Plan Provider rather than a Non-Plan Provider. Section 6 describes how using a Non-Plan Provider can affect your Out-of-Pocket Costs. Health Options' Member Services Associates can answer questions about our Plan Providers.

Plan Providers have contracts with Health Options that can be terminated from time to time, even without notice. If your Plan Provider leaves our network for any reason, we will try to give you at least 60 days' notice. In any case, we will give you as much notice as we can. To find a new Plan Provider, you may review the Provider Directory or contact Member Services.

In some cases, we may continue to cover the care you receive from your departing Plan Provider with the same Out-of-Pocket Costs to allow for a smooth transition to a new Plan Provider. If you are undergoing a course of treatment with a Plan Provider who leaves Health Options' network, you may have the same Out-of-Pocket Costs with that Plan Provider for at least 90 days from when we notify you that your Plan Provider is leaving. If you are a pregnant Member in the 2nd or 3rd trimester and we notify you that your Plan Provider is leaving, you may have the same Out-of-Pocket Costs, related to that pregnancy, with that Plan Provider through postpartum care.

In the event that you are not able to obtain services from a Plan Provider in your area, you or your Provider should call Health Options at 1-855-624-6463 (TTY/TDD: 711) to seek assistance in finding a Plan Provider.

5. Service Area

Health Options' Service Area consists of Maine and New Hampshire. We also contract with a limited number of Plan Providers in Vermont and Massachusetts. Providers not directly contracted with us are considered Non-Plan Providers. Non-Plan Providers within the Service Area are considered Out-of-Network. SERVICES RECEIVED OUTSIDE OUR SERVICE AREA ARE CONSIDERED OUT-OF-NETWORK except for Emergency Services as described in Section 4.B; Services provided at a contracted Center of Excellence as described in Section 2.D.3; and Services provided by the Plan Providers we contract with in Vermont and Massachusetts. Services received from Non-Plan Providers may be at higher cost to you as described in Section 6.

D. Member Rights and Responsibilities

As a Member of the Plan, you have the following rights:

- *You have a right to detailed information about the Organization and your Plan. This may include information about Benefits and services that are covered under or excluded from the Plan, and all requirements that must be followed for Prior Approval.*
- *You have a right to information about your Out-of-Pocket Costs, and an explanation of your financial responsibility for services provided to you.*

- *You have a right to be treated in a manner that respects your privacy and dignity. We will follow applicable laws and our policies when we handle your information.*
- *You have a right to participate with your Providers in making decisions about your health care.*
- *You have a right to voice complaints or file Appeals with the Plan, and to contact regulatory bodies about the Plan.*
- *You have a right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.*
- *You have a right to receive appropriate assistance from Health Options in a prompt, courteous, and responsible manner.*
- *You have a right to be promptly informed of termination or changes in Benefits, services, or Plan Providers.*
- *You have a right to receive an explanation of why a Benefit is denied; the opportunity to Appeal the denial decision; the right to a second level of Appeal with the Plan (Maine Plans only); and the right to contact the Insurance Department listed on the cover of this Agreement.*
- *You have a right to adequate access to Providers near your home or work within the Plan's Service Area.*
- *You have a right to receive detailed information about which services require Prior Approval and how to request Prior Approval.*
- *You have a right to have access to a current list of Plan Providers in the Plan's network.*
- *You have a right to a candid discussion of appropriate or medically necessary treatment options for your conditions regardless of cost or benefit coverage.*
- *You have a right to have a Member Representative help you follow your responsibilities and exercise your rights under the Plan.*

As a Member of the Plan, you have the following responsibilities:

- *You have a responsibility to provide honest and complete information to the Plan and to your Providers.*
- *You have a responsibility to timely notify the Plan of any errors or omissions in your account upon discovery.*
- *You have a responsibility to choose an In-Network Primary Care Provider (PCP) for yourself and any Dependents.*
- *You have a responsibility to read and understand the information that you receive about your Plan.*
- *You have a responsibility to know how to properly access coverage and utilize your Plan.*
- *You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your Providers.*
- *You have a responsibility to follow plans and instructions for care that you have agreed to with your Provider.*
- *You have a responsibility to present your Member identification card before you receive care or, in emergency situations, after you receive care.*
- *You have a responsibility to pay your applicable Deductible, Coinsurance and Copayment amounts.*
- *You have a responsibility to express your opinions, concerns or complaints in a constructive way to the Plan or to your Provider.*
- *You have a responsibility to timely inform the Plan of any changes in family size, address, phone number, or Member eligibility status.*
- *You have a responsibility to make Premium payments on time, even if you have made arrangements with a third party to make such payments.*
- *You have a responsibility to notify the Plan if you have any other insurance coverage.*

2. HOW YOUR PLAN WORKS

A. Care Management and Medical Management/Utilization Review

Community Health Options ("Health Options") is committed to ensuring Members receive high-quality, medically appropriate care. An important part of the Plan is our medical management and care management services. Our medical management team performs utilization review of health services to ensure they are Medically Necessary, evidence-based and delivered in the most effective health care setting.

If you are hospitalized, have complex or serious health conditions, or are transitioning from one health care facility to another, our team will review your situation and determine whether you may benefit from care management services. These services are provided to you at no additional Out-of-Pocket Cost.

When you are hospitalized, our Medical Management team will monitor your care to ensure you receive high-quality services that are most appropriate for your condition. We will also work closely with the Hospital staff to help plan your discharge from the Hospital to help make it a smooth transition and provide you with access to the health care services that are most appropriate for your condition. Our care managers and care navigators work closely with your Primary Care Provider and local care management teams to coordinate your care. Our care managers and care navigators can coordinate your Specialist appointments and help you obtain prescribed care such as Durable Medical Equipment, medical supplies, or Prescription medications.

Health Options applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Under extraordinary circumstances that involve complex care or care management services the Plan may provide Benefits for services that are not listed in the "Covered Services" section 4.B. The Plan may also continue Covered Services beyond the contractual Benefit limit of this Agreement. These decisions are made on an individual basis and a decision to provide alternate services or continue Benefits is not precedent setting, and it does not obligate us to continue to provide those Benefits to you or any other Member in the future. We reserve the right, at any time, to change or stop providing alternate service Benefits or extended Benefits. Should we decide to change or stop your alternate services, we will notify you of that decision in writing.

Members, their caregivers, Providers and local care managers can refer Members for care management services by contacting Member Services at 1-855-624-6463 Monday-Friday, 8am-6pm.

1. <u>Chronic Condition Support (Disease Management)</u>

   As an accredited Health Plan, we work with our Members and Providers to improve the health status of Members with chronic conditions. We believe it is important for you to work directly with your local healthcare Providers, and we are here to provide additional support when needed.

   The goal of Community Health Options' Disease Management program is to empower our Members to effectively self-manage their chronic conditions.

   We believe each Member of our CO-OP contributes to the overall health and wellbeing of our entire community of Members by actively engaging in their own healthcare. When each Member takes responsibility for doing as much as possible to improve his or her health and wellbeing, our entire CO-OP benefits.

   We encourage you to engage with your Primary Care Provider, get recommended health screenings, follow evidence-based, cost-effective treatment that is prescribed by your Providers. If you have a chronic condition, be sure to see your Primary Care Provider or Specialist at least once per year. This improves your health and wellbeing and our entire CO-OP benefits by keeping healthcare costs as low as possible for everyone.

   Our Care Management team monitors the health status of all of Members, and we may contact you by mail, email or phone when we believe you may benefit from additional support.

   This program is strictly voluntary and it is available at no additional Out-of-Pocket cost. You can choose to opt out of our Disease Management program at any time by contacting Member Services at 1-855-624-6463 or by telling the Community Health Options care manager who is calling you. You can always change your mind and opt back in by calling Member Services.

2. <u>Healthy Options: Support of Healthy Living</u>

   Our Healthy Options program offers wellness and health promotion programs designed to provide support for individuals based on their preferred style of engagement. We offer online access to health information and self-

management tools as well as a team of care managers who provide individual health coaching via phone at 1-800-571-8350 at no Out-Of-Pocket cost. For additional information about our Healthy Options program visit www.healthoptions.org or call Member Services at 1-855-624-6463.

B. Reviews of Hospital Admissions

1. Generally

With the exception of Medical Emergency and maternity Hospital admissions, Health Options requires that we be notified before you are admitted to the Hospital. For elective admissions with Prior Approvals on file, your Provider must also notify us within 48 hours of your actual admission date. When you are admitted to a Non-Plan facility, you or your representative have a responsibility to notify Health Options of your admission within 48 hours.

For Medical Emergency and maternity Hospital admissions, you, your Designee, or your Provider must notify us within 48 hours after admission. We will conduct a review of your admission.

Should you be admitted to a Hospital that is a Non-Plan Provider due to a Medical Emergency, your Out-of-Pocket Costs for the Maximum allowable amount, as determined by Health Options, will be at the Plan Provider (or In-Network) cost-sharing level only until your condition is stabilized and reasonably allows you to be transferred to a Hospital that is a Plan Provider. You may be responsible for charges above the Maximum allowable amount.

We will review your situation to determine if continued coverage by a Non-Plan Provider at an In-Network rate is reasonable or if transfer to a Plan Provider is required. If we determine transfer to a Plan Provider is required and you decide to stay at the Non-Plan Provider, the rest of your Inpatient Stay Out-of-Pocket Costs will be at the Non-Plan Provider (or Out-of-Network) cost-sharing level. If we determine, due to cost or medical condition, we should not transport you to a Plan Provider, your inpatient stay will be Approved by Health Options and your Out-of-Pocket Costs for the Maximum allowable amount, as determined by Health Options, will be at the Plan Provider (or In-Network) cost-sharing level. You may be responsible for charges above the Maximum allowable amount.

See Section 6 for more information on how the Plan pays claims.

2. While You Are in the Hospital

We will periodically review your Inpatient Stay at the Hospital while you are still in the Hospital. We want to ensure that you are receiving a proper level of care in the proper setting.

End of Benefits

When we decide that the Plan will no longer cover your Inpatient Stay at the Hospital, we will notify your Provider or the Utilization Review team at the hospital who is acting as your representative during your inpatient stay. We will explain the reason(s) behind our decision and when the Plan will no longer provide Benefits. Once you or your representative has been verbally notified, any Inpatient Stay beyond this time will not be covered by the Plan and you may be personally responsible for any costs relating to the continued Inpatient Stay. We will mail you written notification of this decision to the most current address we have on file for you. You and/or your Provider may request a reconsideration of our decision as described in section 2.F.5.

3. Observation Status

If you have not been admitted to a Hospital but are registered by the Hospital for observation, this means that the Hospital staff is monitoring your health status while awaiting test results. Based on that monitoring and testing you may be admitted as an Inpatient or discharged home for follow up with your personal Provider as an Outpatient. If you are registered for observation, your cost-sharing will be considered "Other Services." If you are not admitted to the hospital, you may incur Emergency Room cost-sharing in addition to the cost-sharing associated with observation status.

C. Getting Care from Your Primary Care Provider (PCP)

1. Choosing Your PCP

Having a strong relationship with a Primary Care Provider (PCP) whom you trust is important to maintaining and improving your health. An important step after you have enrolled in the Plan is to choose a PCP. When you enroll, you have the opportunity to identify PCPs for yourself and each of your Dependents. If you do not choose a PCP when you first begin coverage with Health Options, or if the PCP you select is not available, we will assign a PCP for you. You have the option to change your PCP at any time. To change your PCP, please call Member Services at

1-855-624-6463 or visit your secure Member portal at www.healthoptions.org. To register your secure Member portal visit https://www.healthoptions.org/registration. If your PCP stops being a Plan Provider, we will try to give you 60 days' advance notice. In any case, we will give you as much notice as we can. You will then need to select a new PCP who is available or we will assign one for you.

It is important for you to get to know your PCP soon after your coverage first begins or whenever you choose or are assigned a new PCP. You should have your medical records sent to your new PCP. If you have one or more chronic health conditions, it is important that you see your PCP at least once per year to evaluate and update the status of that condition.

Except where indicated in this Agreement, a Referral from your PCP is not required for visits to Specialists and specialty Providers, but we encourage you to notify your PCP so her or she can help coordinate your care.

Please note that your PCP may recommend a Specialist or other Provider who is not in the Health Options Network. **It is your responsibility to ensure the Providers you receive services from are in the Health Options Network.** Please visit www.healthoptions.org or call Member Services at 1-855-624-6463 (TTY/TDD: 711) if you have questions about the Network status of Providers recommended by your PCP or if you would like to nominate a Provider to be considered for inclusion in the Community Health Options Network.

Certain preventive services as defined in Federal law are covered with no Out-of-Pocket Cost to you when provided by a Plan Provider. Please see the Preventive Services (section 2.H) for more information.

2. Obtaining Care from Your PCP

When you need care, we recommend that you first contact your PCP. Your PCP can help coordinate the care you need. In the event of a Medical Emergency, you should obtain needed care immediately. Your PCP's office can tell you how they cover patient needs outside of business hours.

D. Going to the Hospital or a Specialist

This Plan covers Hospital, Behavioral Health and Specialist services. The Plan does not require Referrals except where indicated in this Agreement, but in some cases, Prior Approval by Health Options is required. Please refer to section 2.F for more information.

1. If You Have a Medical Emergency

If you need Medical Emergency services, you should go immediately to the nearest emergency department or call 9-1-1 or another local emergency number. You do not need Prior Approval for Medical Emergency services.

Medical Emergencies include, but are not limited to:

- Heart attack;
- Stroke;
- Severe trauma;
- Shock;
- Loss of consciousness;
- Seizures; and
- Convulsions.

Once your emergency medical condition is stabilized, Notification and Prior Approval requirements apply for all services that require Notification or Prior Approval.

If you are hospitalized, Notification to Health Options via our Member Services toll free number at 1-855-624-6463 is required within 48 hours of the admission. When you are admitted to a Plan Provider facility, the staff at that facility is required to notify Health Options of your admission. If you are admitted to a Non-Plan Provider facility, you or your designee is required to notify your PCP and Health Options within 48 hours of admission. Your PCP will arrange for any follow-up care you may need.

Your emergency department Out-of-Pocket Costs are listed on the *Schedule of Benefits*. If you are admitted to the Hospital from the emergency department, your Out-of-Pocket Costs for the emergency department visit as outlined in the *Schedule of Benefits* will be waived.

Should you seek Medical Emergency services at a Hospital that is a Non-Plan Provider, your Out-of-Pocket Costs for the Maximum allowable amount, as determined by Health Options (see section 6 for more info), will be at the

Plan Provider (or In-Network) cost-sharing level. You may be responsible for charges above the Maximum allowable amount.

2. Urgent Care Centers

Non-urgent medical conditions can generally wait to be treated by scheduled appointment with your PCP. Medical emergencies that require immediate medical attention should go to the nearest Emergency Room.

Urgent Care Centers may be a good option when you are unable to reach your PCP after routine office hours and you need medical attention that cannot wait until the next day.

E. Health Options Medical Policy

Health Options has a *Medical Policy* to help Health Options determine if services are Medically Necessary. We will utilize our *Medical Policy* only for services that are Covered Services.

Health Options periodically reviews the value and effectiveness of new medical technologies and treatments. Those technologies and treatments that are deemed appropriate will be included as part of our benefit structure.

F. Prior Approval

1. Introduction

Some Covered Services require Prior Approval from Health Options before we will pay Benefits. The Prior Approval program helps us ensure that:

- You are eligible to receive services at the time of the request;
- The requested service is a Covered Service;
- The services you receive are Medically Necessary;
- You receive the appropriate level of care in the appropriate setting;
- Information is shared with your Providers so that your care can be coordinated; and
- We pay the correct amount of Benefits.

If Prior Approval is granted for a service, Benefits will be paid as described in the *Schedule of Benefits* (unless there is a reason to deny Benefits).

If we grant Prior Approval for a Covered Service that is based on information given to us that is fraudulent or materially incorrect, we may retroactively deny Prior Approval for that Covered Service.

Sometimes, your Prior Approval request will be medically reviewed by a Physician (or a qualified clinician for mental health or substance abuse services or a pharmacist for drugs).

We do not pay or give incentives to our employees or contracted Providers to improperly deny or withhold Benefits. Health Options staff involved in Prior Approval decisions must also sign a conflict of interest statement each year.

No Prior Approval is required for Emergency Care.

Emergency Care is a service to be provided in an emergency facility or setting after the onset of an illness, injury or medical condition that manifests itself as symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent layperson who possesses average knowledge of health and medicine to result in (1) placing the Member's physical or mental health in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

a. Prior Approval for Pharmacy

Medications, to include high cost infusions and injections that are dispensed by a pharmacy, must go through our pharmacy prior approval process.

b. Prior Approval for Urgent Service Requests

We will make a decision on a Prior Approval request for Urgent service requests as soon as possible taking into account the medical situation, and within 48 hours after receiving all necessary information to review the request.

If the request is missing information, this may delay our decision. We will let you or your representative know within 24 hours after receiving the request what information we need to make the decision. We will give you or your representative a reasonable amount of time to provide the needed information, which will be at least 48 hours. We

will make the decision as soon as possible, but in no case later than 48 hours after the earlier of (1) our receipt of all of the necessary information, or (2) the request for additional information if additional information is not received.

c. Prior Approval for Ongoing Course of Treatment Involving a Medical Necessity Question

We will make a decision on a Prior Approval request for an ongoing course of treatment involving a Medical Necessity question:

i.) for decisions regarding urgent ongoing course of treatment within 24 hours after receiving the request, provided that the request is made at least 24 hours before the approved treatment time period expires. We will inform you or your representative within 24 hours after receiving the request if we need more information to make the decision.

ii.) for decisions regarding routine ongoing course of treatment within one business day. We will inform you or your representative within one business day after receiving the request if we need more information to make the decision.

Written notification will include the number of extended days or next review date, the total number of units (days or services approved), and the date of admission or initiation of services. We will not approve a request unless we receive all needed information. Ongoing care will be continued without liability to you until you or your representative is notified of the coverage determination.

d. All Other Prior Approval Requests

We will make a decision on requests for Prior Approval not involving Urgent Care or an ongoing course of treatment involving a Medical Necessity question within two working days of receiving all the information necessary to review the request.

If the request is missing information, this may delay our decision. We will let you or your representative and your Provider know within two working days if we require more information after receiving the request. If we determine that outside consultation is necessary, we will notify you or your representative within two working days.

2. Services Needing Prior Approval or Notification

Some services require Prior Approval or review of clinical documentation before Benefits will be provided by the Plan. Some services require that we be notified that you have received services. If you have any questions or need assistance to determine which services require Prior Approval or notification, please visit www.healthoptions.org or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

When receiving services from a non-Plan Provider, if you fail to obtain Prior Approval for a service needing Prior Approval, or if you fail to submit timely notification for a service that requires notification, you may not receive Benefits for that service and you may be responsible for the full cost of the service, if we determine the service was not medically necessary.

Services that require notification (see section 6 for more information about payment of claims)

When obtaining services from Plan Providers, the Plan Provider is responsible for notifying Health Options. When obtaining services from non-Plan Providers, you are responsible for ensuring Health Options is notified. Health Options Utilization Management must be notified in the following manner:

- Call PRIOR TO ADMISSION for Long Term Acute Care (LTAC)
- Call PRIOR TO ADMISSION for Inpatient Pediatric Feeding Program – PRIOR AUTHORIZATION REQUIRED
- Call UPON ADMISSION – All Acute Inpatient; all Acute Rehabilitation; Home Health; Skilled Nursing Facilities;
- Call PRIOR TO TRANSFER from one Acute Care Hospital to another Acute Care Hospital
- NOTIFICATION by the PROVIDER RENDERING OB SERVICES is requested for Inpatient OB Care (pregnancies) UPON ADMISSION

Types of services that generally require Prior Approval or submission of clinical documentation for clinical review. Detail on specific services requiring Prior Approval is available at https://www.healthoptions.org/health-care-professionals/professional-document-and-forms/

- Advanced Imaging
- All Out-of-Network Facilities
- Ambulance (non-emergent)/Air Transportation
- Assertive Community Treatment (ACT)
- Cardiac Surgery/Cardiovascular
- Chemotherapy
- Chiropractic Care/Manipulative Therapy
- Clinical Trials
- Colonoscopy
- Crisis Stabilization Unit (CSU)
- Dental and Orthognathic Related Services
- Durable Medical Equipment (DME), Orthotics, Prosthetics; Oxygen Equipment and Contents
- Ear, Nose and Throat services
- Gastroenterology and General Surgery
- Genetic Testing
- Genitourinary
- Hearing Aids or Repairs
- High cost infusions/injectables
- Home Infusion Services
- Hospice/Hospice Respite
- Hyperthermia Treatment
- Infusions/Injectables
- Intensive Outpatient Programs (IOP)
- Inpatient Procedures/Admissions
- Long Term Acute Care (LTAC) facilities
- Mental Health Residential Treatment Center (RTC) (non-emergent)
- Neurosurgery
- Non-Emergency Ambulance Service
- Nutritional Products/Services
- Ophthalmology
- Orthopedics
- Out-of-Network Skilled Nursing Facilities, Long Term Acute Care, Acute Inpatient Rehab, Home Health Agencies, Behavioral Health Services
- Outpatient Electroconvulsive Therapy (ECT)
- Outpatient Services
- Pain Management-Spinal Pain
- Partial Hospitalization Programs (PHP)
- Plastic, Reconstructive and/or Cosmetic Procedures
- Potentially Experimental or Investigational Services
- Psychological and Neuropsychological Testing
- Radiation Oncology
- Residential Detoxification and Rehab (non-emergent)
- Sleep Study
- Transplant-related services including initial consult and evaluations
- Transcranial magnetic stimulation (TMS)
- Wound Care Clinic
- Wound Care Products and Procedure

3. Seeking Prior Approval

If you use a Plan Provider, he or she is responsible for obtaining Prior Approval for you. If your Plan Provider fails to acquire Prior Approval for you, you will not be financially responsible for this failure.

If you use a Non-Plan Provider or your services are ordered by a Non-Plan Provider, you (or your Designee) are responsible for ensuring Prior Approval is obtained for any services requiring Prior Approval. To seek Prior Approval, please have your Provider contact Health Options at 1-855-624-6463 (TTY/TDD: 711). Requests for Prior Approval require review of clinical information from your Provider. Health Options will not accept Prior Approval requests from Members or non-Provider Designees.

If you seek services from a Non-Plan Provider and fail to obtain Prior Approval for a service needing Prior Approval, or you fail to provide notification as required, you may not receive Benefits for that service and you may be responsible for the full cost of the service. Approved Covered Services provided by Non-Plan Providers apply towards your Out-of-Network cost-sharing as described in your *Schedule of Benefits.* Health Options pays Benefits up to the Maximum allowable amount. The Out-of-Network Provider may balance bill you for submitted charges that exceed the Maximum allowable amount.

Services for Medical Emergencies do not need Prior Approval. In the event of an admission due to a Medical Emergency, you (or your Designee) must contact Health Options within 48 hours after you are admitted or as soon as reasonably possible.

4. Prior Approval Decisions

We will notify you or your representative, and your Provider, of our Prior Approval decisions. Our Prior Approval decisions will discuss whether the requested service is Medically Necessary and is a Covered Service. A denial of coverage based on Medical Necessity (sometimes referred to as an Adverse Health Care Treatment Decision) are initially communicated verbally to the Provider, then followed up in writing to you or your representative and the Provider. The written notification cites the reason(s) why the decision was made and includes information about the Appeals process and the right to request in writing copies of any clinical criteria applied in a denial of coverage decision. Additionally, Members will receive written notification of any denial of coverage that is based on non-covered Benefits or Benefit limits that have been reached (known as an Adverse Benefit Determination). The written notification cites the reason(s) why the decision was made and includes information about the Appeals process and the right to request in writing copies of any criteria applied in a denial of coverage decision. Adverse Benefit Determinations also include Claim Denials and are described in section 6.A. For more information on the process for appealing Adverse Health Care Treatment Decisions or Adverse Benefit Determinations, please see section 8, Appeals and Complaints.

5. Reconsideration of Adverse Health Care Treatment Decision

a. In cases involving an initial or ongoing treatment Adverse Health Care Treatment Decision, the rendering Provider is given the opportunity to request by telephone, fax, electronically, or in writing on behalf of the Member a reconsideration of adverse decisions by the reviewer making the decision.
b. The Provider has up to five (5) working days from the date of the verbal Adverse Health Care Treatment Decision notification to request a reconsideration.
c. The reconsideration shall occur within one working day after the receipt of the request and shall occur between the rendering Provider and the reviewer who issued the denial or a peer designated by the Chief Medical Officer (CMO) if the reviewer who issued the denial is not available within one working day.
d. Decisions overturned by the reviewer during reconsideration will be reprocessed as Approved.
e. Decisions upheld by the reviewer during reconsideration will be processed as ‘denied’ reserving all appeal rights.

G. Prescription Drugs

1. Formulary

Health Options reviews and selects drugs for the formulary that will be safe, effective, and as affordable as possible. These formulary selections are based on their therapeutic value, side effects, and cost compared to similar medications. Health Options regularly evaluates the formulary to ensure it is up-to-date. Updates to the formulary will be posted to the Health Options website within 72 hours of the change.

The formulary lists drugs alphabetically by drug name, then alphabetically by drug type. The formulary contains information for each drug, including the tier, prior approval and step therapy requirements (if any), quantity limits (a limit to how much of the drug the Member may receive each fill and/or a limit of fills per month) and any other requirements. To determine the cost-sharing for a particular tier, you should refer to your *Schedule of Benefits*. The cost-sharing described on your *Schedule of Benefits*. You can fill your prescriptions through participating Retail Pharmacies, home delivery, and/or specialty pharmacies.

Determination of coverage is made by Health Options and our Pharmacy Benefits Manager (PBM), Express Scripts. Your formulary is evaluated on an ongoing basis, and could change. Health Options does not send separate notices if a brand-name drug becomes available as a generic drug. The pharmacist usually tells you this information when you fill your next prescription. If you have more questions about the formulary or your Out-of-Pocket Costs, please contact Member Services at 1-855-624-6463 (TTY/TDD: 711). For access to the formulary, please visit our website at https://www.healthoptions.org/Documents/2017_Individual_Formulary.

2. Specialty Drugs

Community Health Options has partnered with Express Scripts to implement a specialty drug program that: increases savings to our Members and the Plan; improves Member adherence; and allows Health Options' Members 24/7 access to specialty-trained pharmacists and nurses to improve clinical outcomes.

You will be able to fill the first 30-day prescription of most specialty drugs at the retail pharmacy at the cost-sharing listed on your *Schedule of Benefits*. In order to continue paying the cost-sharing listed on your *Schedule of Benefits*, specialty drugs must be filled through our preferred specialty pharmacy.

After your initial fill at a retail pharmacy, Express Scripts will send you information about how to fill your specialty drug through the preferred specialty pharmacy and the costs you will incur if you choose not to fill through the preferred specialty pharmacy. This information will be sent to the latest address on file for the Member. For most specialty drugs, you may continue to fill your prescriptions at a pharmacy other than our preferred specialty pharmacy but you will be required to pay 100% of the allowed drug cost. In this case, the full allowed cost will apply to your Out-of-Pocket costs.

Certain specialty drugs are considered "mandatory" or "exclusive specialty" and must be filled through our preferred specialty pharmacy. These drugs are indicated on the formulary as mandatory specialty. You will be able to fill the first 30-day prescription at the retail pharmacy at the cost-sharing listed on your *Schedule of Benefits*. In order to continue paying the cost-sharing listed on your *Schedule of Benefits*, mandatory specialty drugs must be filled through our preferred specialty pharmacy.

If you continue to fill these prescriptions at a pharmacy that is not the preferred specialty pharmacy, you will be responsible for 100% of the drug cost. These costs are not covered by the Plan and will not apply to your Out-of-Pocket costs.

3. Step-Therapy

Certain drugs require step-therapy. This means that to receive coverage, you will need to try proven, safe and cost-effective medicine before using the drug that requires step-therapy. Your Provider will be required to submit documentation to obtain Approval for a drug requiring step-therapy. Your Provider can request to bypass step-therapy by requesting Prior Approval.

4. Exceptions to Coverage

Health Options has a process for allowing exceptions to our formulary. To obtain coverage for a drug not on our formulary, you, your Designee, or the prescribing Provider must submit a request to Health Options' PBM with a clinical rationale for the exception. Our PBM will make a decision within 48 hours, or in exigent circumstances, within 24 hours, upon receipt of all required information. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

In the case of exigent circumstances, if the request for coverage is approved, coverage for the drug will be available for the duration of the exigency. If the request for coverage is approved, the drug will be covered as a Tier 4 drug (cost-sharing will apply as listed in the *Schedule of Benefits*), and the prescription will be considered a Covered Service.

You, your Designee, or the prescribing Provider may request an accredited independent review organization review the denial of an exception request. If you or your Designee are requesting the exception, you will need to provide

the prescribing Provider's information so our PBM can contact the prescribing Provider to obtain information to support the request.

5. Prescription synchronization

Prorated daily cost-sharing rates apply to prescriptions dispensed by an In-Network pharmacist for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling a prescription for less than a 30-day supply is in the best interest of the Member and the Member requests or agrees to less than a 30-day supply in order to synchronize the refilling of that prescription with the patient's other prescriptions. The requirement does not apply to prescriptions for (a) solid oral doses of antibiotics; or (b) solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist a patient with compliance. .

6. 90-Day Program

Health Options offers a 90-day supply program that gives you the convenience of getting up to a 90-day supply of certain preferred generic and preferred brand maintenance drugs at participating retail pharmacies. If you get a prescription filled on a regular, recurring basis, talk to your Provider about writing a prescription for a 90-day supply. A list of pharmacies participating in the 90-Day Program can be found at www.healthoptions.org.

7. Home Delivery

You may obtain a 90-day supply of covered maintenance drugs and certain covered controlled substances by mail through our preferred home delivery pharmacy. The use of home delivery is recommended for drugs used to treat chronic, long-term conditions, rather than drugs for short-term treatment. Contact Member Services for more information on our home delivery program. Through the preferred home delivery program, you will have 24/7 access to pharmacists for consultation.

If the drug you are receiving under our PBM's 90-day home delivery program is subject to a co-payment, your co-payment will be the same as two 30-day prescriptions (drugs specified as specialty or mandatory specialty are excluded). If the drug you are receiving under our PBM's 90-day Home Delivery program is subject to deductible and/or coinsurance, you will be required to pay the applicable cost-sharing for the full 90-day supply. You may benefit, however, from lower overall costs for most drugs through the PBM's Home Delivery program.

Copay Assistance Program

By utilizing the home delivery program, Express Scripts can enroll you in available copay assistance plans to save you money.

8. Continuing Prescriptions from a Prior Insurance Carrier

If you have received Prior Approval for a prescription drug from your former insurance carrier, and that prescription drug also requires Prior Approval from Health Options, we will honor the prior authorization up to 30 calendar days to ensure you can obtain your prescription without interruption while we conduct a review. You have the right to request a review with your Provider. If your Provider participates in the review and requests that your prior approval be continued, we will honor the prior carrier's approval while we perform a review, not to exceed 6 months. Continued approval will be determined based on the decision from our review. Please call Member Services at 1-855-624-6463 and ask for a referral to our Care Management team to continue a prescription from your prior insurance carrier.

9. Prescription Refills

The Plan only provides Benefits for prescription refills when you have taken 75% of the medication from a retail pharmacy or 75% from home delivery, based on the dosage and day supply prescribed by your Provider. The Plan does not provide Benefits for refills exceeding the number specified by the Provider or for refills dispensed after one year from the date of original prescription order.

Early refills are available for one refill of a prescription for eye drops if the following criteria are met: The Member requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing Provider have elapsed; the prescribing Provider indicated on the original prescription that a specific number of refills are authorized; the refill requested by the Member does not exceed the number of refills indicated on the original prescription; the prescription has not been refilled more than once during the period authorized by the prescribing Provider prior to the request for an early refill; and the prescription eye drops are a covered benefit under the Plan.

10. Exclusions

The Plan does not provide Benefits for certain drugs or appliances as listed in section 5 (Exclusions from Benefits) unless otherwise stated.

H. Preventive Services

Health Options covers certain Preventive Care and tests to identify diseases or medical conditions prior to any signs or symptoms being present. Under the terms of the Plan, Services defined in federal law that meet the criteria of Preventive Care are covered at no Out-of-Pocket Costs to you when you receive these services from a Plan Provider. You will be responsible for paying applicable cost-sharing for:

a. Preventive Services rendered by non-Plan Providers,
b. Services that are not defined in federal law as Preventive Services, or
c. Services that do not qualify as Preventive under the federal law.

If a Provider recommends a service or test based on an office visit (including a Preventive exam), your symptoms, or a prior diagnosis or treatment, the service or test will be considered diagnostic and will ***not be eligible*** for coverage as a Preventive Service.

For complete information on services that are covered at no Out-of-Pocket Costs to you, refer to Section 4.B.54.

3. ENROLLMENT AND ELIGIBILITY

Important Note: If this Plan is purchased through the Federally Facilitated Marketplace ("the Marketplace"), enrollment in and eligibility for coverage under the Plan is subject to the rules of the Marketplace. You must begin the enrollment process through the Marketplace to be eligible for Catastrophic coverage.

A. Enrollment

You can enroll under the Plan during an annual Open Enrollment Period or a Special Enrollment Period. The only time you are able to make changes to your Plan is during the annual Open Enrollment Period or when you are eligible for a Special Enrollment Period.

1. 10-Day Agreement Review

   At the start of each Plan year, you will have 10 days from the effective date of your coverage to end your Agreement. Your Premium will be refunded if you cancel during this period. See the first page of your Agreement or contact Member Services to learn more about this "free look" period.

2. Special Enrollment

   During the year, if you have certain qualifying life-changing events, you and your Dependents can enroll for coverage under the Plan through "Special Enrollment." Special qualifying events, such as birth or adoption of a child, marriage, loss of other qualified health insurance coverage, or changes in eligibility for other public service programs, will trigger a Special Enrollment Period. For guidance on qualifying events, contact the Marketplace or Community Health Options' Member Services.

   To take advantage of a Special Enrollment Period, you must complete the enrollment process by visiting the Marketplace to complete information about a change in circumstances or by visiting www.healthoptions.org to complete a "Special Enrollment Period Qualifying Event" web form. If you do not have access to the internet, you may also submit a completed paper *Application* to Health Options or the Marketplace, as applicable. You must complete the enrollment process for new Dependent coverage within 60 days of the qualifying event.

   If you become a Member or add new Dependents through a Special Enrollment Period, the effective date of coverage depends on the type and date of event, as well as when Community Health Options ("Health Options") receives premium payment and the completed enrollment information. You will be notified of the effective date of coverage.

B. Member and Dependent Eligibility

If this Plan is being offered through the Marketplace, the Marketplace will determine who is eligible to enroll in the Plan. The Marketplace may have additional or different eligibility criteria than those described in this Agreement. If you need to make changes to your plan, you will need to contact the Marketplace directly or visit healthcare.gov. If this Plan is being offered direct from Health Options, Health Options will determine who is eligible to enroll according to state and federal law. If you need to make changes to your plan, you will need to contact your Broker or Health Options directly.

1. Member Eligibility

   You are a Member of this Plan if you are enrolled as a Subscriber or Dependent of the Subscriber. If this Plan is being offered through the Marketplace, the Marketplace will make eligibility determinations in accordance with applicable law and based upon your *Application*. If you purchased this Plan direct from Health Options, we will make eligibility determinations in accordance with applicable law, your *Application*, and payment of the initial Premium. Subscribers must reside in Maine.

2. Dependent Eligibility

   In order to be a Dependent, a Member must be:

   a. The Subscriber's legal spouse or legal domestic partner as recognized under applicable state law.
   b. A child, who is under age 26, of the Subscriber or the Subscriber's spouse or domestic partner, including newborn children, biological children, adopted children or children Placed for Adoption, stepchildren, children placed in foster care, and children for whom the Subscriber or the Subscriber's spouse/domestic partner is a legal guardian. *NOTE: A Dependent who turns 26 years of age will remain covered for the remainder of the Calendar Year unless coverage terminates. The Dependent will not be renewed into the Plan for the following Calendar Year unless documentation is provided to the Marketplace and Health Options that shows the Dependent meets other requirement described below (Sections 3.B.2.c-d).*
   c. An unmarried child of the Subscriber or the Subscriber's spouse/domestic partner who, as of the date the child turns age 26 or older, is mentally or physically unable to earn his or her own living and is chiefly financially dependent on the Subscriber.

d. A child who is eligible as a Dependent because of a Qualified Medical Support Order ("QMSO") or other court or administrative order requiring medical coverage for a child of a Subscriber or spouse/domestic partner of the Subscriber. Such child will be eligible for medical coverage as stated in the QMSO or other court or administrative order.

A QMSO is a judgment, decree, or order issued by a court or administrative agency that meets certain federal law requirements.

3. Proof of Eligibility

Health Options or the Marketplace may require the Subscriber to submit reasonable evidence of eligibility for Dependent coverage from time to time. Failure to provide this information may result in termination of coverage for a Dependent. For example, upon enrolling a newborn we may ask for a copy of the birth certificate. Please contact Health Options if you have questions about what evidence Health Options may require.

C. Effective Dates

Your coverage will begin under the Plan on the effective date of your Agreement if the first month's Premium is received in full by Health Options on or before the effective date. You will be informed of the effective date. You will not receive Benefits for any services, supplies, or equipment provided to you or received by you before your individual effective date of coverage under this Agreement.

1. New Dependents

New Dependents may be added by paying the applicable Premium and completing enrollment for:

a. Marriage or beginning of a legal domestic partnership (and the spouse's/domestic partner's child(ren), if applicable)

Coverage is effective the first day of the month following the completion of the enrollment. A completed *Application* submission to us or the Marketplace, as applicable, is required within 60 days from the date of marriage or legal domestic partnership.

2. Birth or adoption

A newborn is automatically covered for 31 days from the moment of birth unless the Subscriber notifies us that the newborn will not be covered under this Agreement. For continuous coverage beyond 31 days from birth, you must submit a completed *Application* to us or the Marketplace, as applicable, within 60-days from birth.

For purposes of this section, the term "newborn" includes a newly born child of the insured or Subscriber or a newly born child of a Dependent child of the insured or Subscriber. Grandchildren of the insured or Subscriber are not eligible for coverage beyond the initial 31-day period following birth.

Coverage for routine newborn care will be attributed to the mother's coverage until the mother's discharge. If the newborn remains in the Hospital after the mother is discharged, or if services beyond the scope of routine newborn care are provided, those services will be subject to Deductible and Coinsurance, if applicable, of the newborn. See the Covered Services Section 4.B.

a. Adoption or Placement for Adoption

An adopted child or child Placed for Adoption is covered for 31 days from the date of adoption or Placement for Adoption, upon notification. For continuous coverage beyond 31 days from adoption or Placement for Adoption, you must submit a completed *Application* to us or the Marketplace, as applicable, within 60-days from birth.

b. Legal guardianship

Coverage is effective the date of the court order appointing the guardian if the completed *Application* is received within 60 days from the date of the court order.

c. Subscriber becomes legally responsible for a Dependent's health care coverage

Coverage is effective the date of the court order or other event creating such legal responsibility if the completed *Application* is received within 60 days from the date of the court order or event.

d. Other situations

Other types of Dependents allowed by law must be enrolled as required by law. You may contact Health Options Member Services or the Marketplace, as applicable, if you have questions.

To obtain Dependent coverage under this section, you must submit a completed enrollment to Health Options or the Marketplace, as applicable, within 60 days after an event listed in this section.

If you fail to submit a completed *Application* during the 60-day period as outlined above, your Dependent can be added during the annual Open Enrollment Period, or other special enrollment period required by law, by submitting a completed *Application*.

3. Eligibility Changes

   It is the Subscriber's responsibility to promptly inform Health Options and the Marketplace, as applicable, of all changes that affect Member and Dependent eligibility. For more information reporting eligibility changes visit Healthcare.gov at https://www.healthcare.gov/reporting-changes/.

D. Paying your Membership Premium

When you purchase coverage under the Plan, you will be billed for the Premium on a monthly basis. Payment for the Premium is due the first day of each month for which coverage is provided. No grace period applies to the Binding Premium Payments.

1. Members Not Receiving Tax Credits

   For Premiums owed following the Binding Premium Payments, if you do not pay the Premium in full on or before the first day of the month for which Coverage is provided, you will have a 31-day grace period to pay the outstanding Premium owed. During the grace period, your coverage will not lapse. If we do not receive the full Premium by the end of the grace period, then we will terminate your coverage under the Plan and this Agreement. Except as described in Section 9 of this Agreement, we will not allow reinstatement after the grace period ends. We reserve the right to take necessary steps to collect outstanding Premiums.

2. Members Receiving Tax Credits

   Members who receive Advanced Premium Tax Credits (within the Marketplace) and have made the Binding Premium Payment, but who subsequently fail to pay the Premium in full, will have a three-month grace period to submit full payment of outstanding Premium due. Health Options will pay appropriate claims for the first month of the grace period only. Health Options will hold claims during the remainder of the grace period.

   Health Options will stop holding claims when the full Premium amount owed is paid in full prior to the end of the grace period, Health Options will terminate coverage under the Plan and this Agreement, and the Member will be responsible for paying for any services received during the final two months of the grace period.

3. Third-Party Payment of Premiums

   There may be instances where someone other than the Member pays the Member's Premium under this Agreement. This is sometimes called "third-party payment of Premiums."

   Health Options will permit Members' family members, Designees, and legal representatives to pay Premiums on behalf of Members. Health Options will also permit Ryan White HIV/AIDS Programs; Indian tribes, tribal organizations, and urban Indian organizations; state, federal and local government programs; and private, nonprofit foundations approved by Health Options to make Premium payments on behalf of Health Options Members.

   If a Provider, pharmaceutical company, or other commercial health care entity submits a payment for a Premium on behalf of a Member, Health Options reserves the right to reject such payments, whether paid directly or indirectly by the entity. We will notify you if we have rejected this type of payment. If we reject a third-party Premium payment, you will continue to owe any Premium due as required under this Agreement.

4. Premium Changes

   Health Options files rates with the applicable State and Federal regulatory bodies on an annual basis. Rates are approved for the Calendar Year. Health Options Members will be given at least 60 days' notice of any changes to existing rates for their effective plan. Members that enroll in the last quarter of the Calendar Year should check the following year rates during Open Enrollment.

E. Rebates

To the extent required by law, Health Options may issue a rebate of a portion of your Premium back to you.

F. Explanation and Notice to Parent

If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent; An explanation of any proposed change in the terms and conditions of the policy; Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified. In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy.

4. COVERED SERVICES

This section contains information on the Covered Services under your Plan. Member Out-of-Pocket Cost information (Copayments, Coinsurance, and Deductibles) that apply to your Plan are listed in your *Schedule of Benefits*. Benefits are administered on a Calendar Year basis.

A. Requirements

To be covered and be eligible for Benefits under the Plan, all services and supplies must meet all of the following requirements:

1. Listed as a Covered Service;
2. Be rendered by a Provider within the scope of such Provider's license or certification;
3. Be Medically Necessary;
4. Not be indicated as excluded in the "Exclusions from Benefits" section (see section 5);
5. Be received while an active Member of the Plan; and
6. Receive Prior Approval, if applicable. This requirement does not apply to care needed in a Medical Emergency and certain other services (see section 2.F).

Services that are not Covered Services, and services related to non-Covered Services, are not eligible for Benefits. To receive maximum Benefits for Covered Services, you must follow the terms of this Agreement. Benefits for Covered Services are based on the Maximum Allowable Benefit for such services. Deductible amounts are limited to the Maximum Allowable Benefit. No Benefits are available for amounts that exceed Community Health Options' ("Health Options") Maximum Allowable Benefit.

The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Services and does not guarantee payment. Your cost-sharing amounts are shown on your *Schedule of Benefits*.

B. Covered Services

The following services are Covered Services under the Plan:

1. Allergy Testing and Injections. The Plan provides Benefits for allergy testing and injections. Coverage includes allergy shots for desensitization.

2. Ambulance Service. The Plan provides Benefits for Medically Necessary ambulance services. Ambulance Services are a Covered Service when one or more of the following criteria are met:

   You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.

   You are taken:

   i. From your home, scene of accident or medical Emergency to a Hospital;
   ii. Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital; or
   iii. Between a Hospital and a Skilled Nursing Facility (ground transport only) or Approved Facility (requires Prior Approval).

   The Plan provides Benefits only for ambulance transportation to the nearest Hospital that can provide the required care you need. Benefits also include Medically Necessary treatment of a sickness or illness by medical professionals during an ambulance service, even if you are not taken to a Facility.

   Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

   Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Provider are not Covered Services. Trips to a Provider's office, clinic, morgue or funeral home are examples of non-covered ambulance services.

   Ground Ambulance

   Services are subject to Medical Necessity review by the Plan. Ambulance services for non-Emergency Hospital to Hospital transports require Prior Approval. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Provider are not Covered Services. Trips to a Provider's office, clinic, morgue or funeral home are examples of non-covered ambulance services.

Air and Water Ambulance

Air Ambulance Services are subject to Medical Necessity review by the Plan. The Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing, or water transportation. Air and water ambulance services for non-Emergency Hospital to Hospital transports require Prior Approval.

Air Ambulance transport from one Hospital to another Hospital is a Covered Service if Medically Necessary and if transportation by ground ambulance would endanger your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Transport from one Hospital to another Hospital is Covered only if the Hospital to which you are being transferred is the nearest one with medically appropriate facilities.

Fixed wing or rotary wing air ambulance is furnished when your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because you are located in a place that is inaccessible to a ground or water ambulance provider.

3. Ambulatory Surgery Centers. The Plan provides Benefits for certain Covered Services provided by Ambulatory Surgery Centers. Covered Services vary according to the scope of a specific Ambulatory Surgical Center's license.

4. Anesthesia Services. The Plan provides Benefits for anesthesia only if administered while a Covered Service is being provided. An exception is provided under section 4.B.17. No Benefits are available for local or topical anesthesia unless it is part of a regional nerve block.

5. Asthma Education. The Plan provides Benefits for Health Options approved asthma education programs for Members and their families.

6. Autism Spectrum Disorders Treatment. The Plan provides Benefits for the following Medically Necessary services for the treatment of Autism Spectrum Disorders for Members:

   a. Any assessments, evaluations, or tests by a licensed Provider or licensed psychologist to diagnose whether a Member has an Autism Spectrum Disorder.
   b. Habilitative or rehabilitative services, including Applied Behavior Analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be covered by the Plan, Applied Behavior Analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.
   c. Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor, or clinical social worker.
   d. Therapy services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.

   The Primary Care Provider, an appropriately credentialed treating specialist, a psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in neurology, or a licensed psychologist with training in psychology must determine that a service under this section is Medically Necessary and is consistent with nationally recognized treatment standards for the condition such as those set forth by the American Academy of Pediatrics. Such determination must be renewed annually.

   The Provider must submit a treatment plan, and such treatment plan must be updated no more frequently than on a semi-annual basis.

   Coverage for prescription drugs for the treatment of Autism Spectrum Disorders will be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition.

   Habilitative and rehabilitative services (such as Occupational Therapy, Physical Therapy and Speech Therapy) are subject to the limits defined in this Agreement.

7. Blood Transfusions. The Plan provides Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

8. Breast Cancer Treatment. The Plan provides Benefits for breast cancer treatment, including prostheses and the following services:

   a. Inpatient care for a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer is covered for a period of time determined to be Medically Necessary by the attending Physician, in consultation with you.
   b. If you elect breast reconstruction following mastectomy surgery, the Plan covers reconstruction in the manner you and your Provider choose.

   Coverage includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. See section 4.B.9.

   As required by Maine and federal law, the Inpatient length of stay for a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer will be decided by the attending Provider in consultation with you.

9. Breast Reconstruction. If a Member receives Benefits in connection with a mastectomy and the Member elects breast reconstruction in connection with such mastectomy, to the extent required by federal law, the Plan provides Benefits for, in a manner determined in consultation with the attending Physician and the Member:

   a. All stages of reconstruction of the breast on which a mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses and physical complications of the mastectomy, including lymphedemas.

   Coverage for external breast prostheses is limited to two (2) prostheses per breast, per Calendar Year. The Maximum Allowed Amount for breast prostheses includes the cost of fitting for the prosthesis. The Plan provides Benefits for post-mastectomy bras worn with breast prosthesis. Coverage for post-mastectomy bras is limited to three (3) bras per Member, per Calendar Year.

   Cosmetic breast reconstruction is not covered under the Plan. This includes, but is not limited to: reconstruction of a previously reconstructed breast due to normal aging; reconstruction of a breast that was not the result of a mastectomy; and replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.

10. Breast Reduction Surgery and Symptomatic Varicose Vein Surgery. To the extent required by Maine law, the Plan provides Benefits for breast reduction surgery and symptomatic varicose vein surgery determined to be Medically Necessary by a Physician.

11. Cardiac Rehabilitation. Medically Necessary Phase I Cardiac Rehabilitation is covered in an inpatient setting. Medically Necessary Phase II Cardiac Rehabilitation is covered on an outpatient basis for up to 36 visits per cardiac episode per Member per Calendar Year. Prior Approval is required.

12. Chemotherapy Services. The Plan provides Benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels unless approved by us for medically accepted indications or as required by law. Any FDA treatment investigational new drugs are not covered unless approved by us for medically accepted indications or as required by law. The Plan provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.

13. Chiropractic Care/Therapeutic, Adjustive and Manipulative Services. The Plan provides Benefits for Medically Necessary chiropractic care. The Plan provides Benefits for therapeutic adjustments and manipulations for treating acute musculo-skeletal disorders. These services may be rendered by a Provider within the scope of such Provider's license or certification and are not limited to chiropractic doctors. No benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in conjunction with an active course of treatment.

    Benefits are limited to 40 visits per Member per Calendar Year. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

14. Clinical Trials. The Plan provides Benefits for items and services you receive as a "qualified enrollee" participant in an "approved clinical trial" that would normally be covered under the Plan for Members who are not enrolled in a clinical trial.

    An "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health. This includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Plan provides Benefits under this section for the following clinical trials:

a. Federally funded trials approved or funded by one or more of the following:

   i. The National Institutes of Health (NIH)
   ii. The Centers for Disease Control and Prevention
   iii. The Agency for Health Care Research and Quality
   iv. The Centers for Medicare and Medicaid Services
   v. Cooperative group or center of any of the entities described in (i) through (iv) or the Department of Defense or Department of Veterans Affairs
   vi. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
   vii. Any of the following in (1) through (3) below if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

      1. Department of Veterans Affairs
      2. Department of Defense
      3. Department of Energy

b. Studies or investigations done as part of an investigational new drug application reviewed by the FDA
c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application

An enrollee is considered "qualified" if the enrollee meets the following conditions: (1) The enrollee has a life-threatening illness for which no standard treatment is effective, (2) the enrollee is eligible to participate according to the clinical protocol with respect to treatment of such illness, (3) the enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee and (4) the enrollee's referring Provider has concluded that participation in such a trial would be appropriate based upon the satisfaction of conditions 1 through 3. A "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The Plan may deny Benefits for:

a. The Investigational item, device, or service, itself; or
b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member;
c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
d. An item or service that is paid for, or should have been paid for, by the sponsor of the trial.

15. Colorectal Cancer Screenings. The Plan provides Benefits for colorectal cancer screenings as described in the guidelines of a national cancer society for asymptomatic Members who are:

a. 50 years of age or older; or
b. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.

For purposes of this section, "Colorectal Cancer Screening" means a colorectal cancer examination and laboratory test recommended by a Provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

If a colonoscopy is recommended as the colorectal cancer screening method and a lesion is discovered and removed during the colonoscopy, Benefits will be paid for the screening colonoscopy as the primary procedure. See section 2.H for information about free preventive services as defined in federal law.

16. Contraceptives/Family Planning. The Plan provides Benefits for family planning and Benefits for prescription contraceptive drugs and devices approved by the FDA to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis. For women, one form of contraception in each contraceptive method (as identified by the FDA) is covered by the Plan without cost-sharing when administered or prescribed by a Plan Provider. This includes, but is not limited to, barrier methods, hormonal methods, surgical implanted and over the counter devices. If a contraceptive method is only available over-the-counter, your Provider must provide a prescription to be submitted by you with Health Options' reimbursement form in order to be reimbursed

under the Plan. The reimbursement form can be found at https://www.healthoptions.org/find-a-form. For more information about the reimbursement process, contact Member Services at 855-624-6463. Coverage includes sterilization procedures, and patient education and counseling. See section 2.H for information about free preventive services as defined in federal law.

The Plan provides Benefits for abortions in the case of rape or incest, or for pregnancy which, as certified by a Provider, places the woman in danger of death unless an abortion is performed (i.e., abortions for which Federal funding is allowed). Elective abortions are not covered.

17. Dental Procedures. The Plan provides Benefits for general anesthesia and associated facility charges for the Medically Necessary Hospital or surgical day care facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a Member who is classified as vulnerable. Examples of vulnerable Members include, but are not limited to the following:

    a. Infants;
    b. Individuals exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
    c. Individuals with acute infection;
    d. Individuals with allergies;
    e. Individuals who have sustained extensive oral-facial, or dental trauma; and
    f. Individuals who are extremely uncooperative, fearful, or anxious.

    The Plan **does not** provide Benefits under this section for any dental procedures or the dentist's fee.

18. Dental Services. The Plan provides Benefits for the following Medically Necessary dental services:

    a. Setting a jaw fracture;
    b. Removing a tumor (but not a root cyst);
    c. Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting.
    d. Treatment to repair or replace natural teeth resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the Accidental Injury is received within 6 months of the date of the injury or the Member's effective date of coverage, whichever is later.
    e. Repairing or replacing dental Prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever, is later.

    The Plan does not provide Benefits for services for dental damage that occurs as a result of normal activities of daily living or extraordinary use, such as injury to teeth sustained due to biting or chewing. The Plan does not provide Benefits for dental implants or any type of artificial tooth roots, including when in conjunction with dental Prostheses.

19. Diabetes Services and Supplies. The Plan provides Benefits for the following diabetic services and specific supplies that are determined to be Medically Necessary by the Member's treating Provider:

    a. Maine Department of Health and Human Services-approved Outpatient self-management training and educational services used to treat diabetes;
    b. Insulin;
    c. Insulin pumps;
    d. Oral hypoglycemic agents;
    e. Glucose monitors;
    f. Test strips;
    g. Syringes; and
    h. Lancets.

    Covered diabetic supplies are listed on our formulary. A copy of the current formulary is available online at www.healthoptions.org or you may request a copy of the formulary by calling Member Services at 1-855-624-6463 (TTY/TDD: 711).

20. Diagnostic Services. The Plan provides Benefits for Diagnostic Services, including diagnostic laboratory tests and x-rays, when they are ordered by a Provider to diagnose specific signs or symptoms of an illness or injury. Services not defined as Preventive Care under section 4.B.54 will be considered Diagnostic Services. Services covered under this section include the services of a Physician with a specialty in radiology.

Certain imaging services require Prior Approval. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

21. Dialysis. The Plan provides Benefits for Medically Necessary hemodialysis and dialysis on an Inpatient or Outpatient basis, or at home. When the Member is eligible for coverage of hemodialysis and dialysis under Medicare, the Plan provides Benefits only to the extent payments would exceed what would be payable by Medicare. Your PCP should make all arrangements for hemodialysis and dialysis care. Coverage for hemodialysis and dialysis in the home includes nondurable medical supplies, drugs, and equipment.

    To be covered, hemodialysis and dialysis services under this section must be ordered by a Physician.

22. Durable Medical Equipment and Prostheses. The Plan provides Benefits for the rental or purchase of Durable Medical Equipment. Whether you rent or buy the equipment, the Plan provides Benefits for the least expensive (and, if applicable, lowest tech) equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased Durable Medical Equipment will follow Medicare guidelines and are subject to Prior Approval. The Plan does not provide Benefits for the repair or replacement of rented equipment. The Plan does not provide Benefits for duplicative Durable Medical Equipment.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    Supplies are covered if they are necessary for the proper functioning of Durable Medical Equipment. Supplies for Durable Medical Equipment are not subject to any Durable Medical Equipment maximum applicable to the Plan. Batteries for Durable Medical Equipment are not covered.

    The Plan provides Benefits for Prostheses. Prostheses are prosthetic devices to replace, in whole or in part, an arm or a leg. Prostheses include artificial limbs and prosthetic appliances. Coverage extends to such prosthetic devices, replacing in whole or in part an arm or a leg, that are determined by a Provider to be the most appropriate and least expensive model that will adequately meet the Member's medical needs. The Plan also covers repair or replacement of such prosthetic devices that is determined to be appropriate by a Provider. The Plan does not provide Benefits for replacement prosthesis unless the Member's medical needs are not being met by the current prosthetic or it is broken and cannot be repaired.

    Coverage does not extend to prosthetic devices designed exclusively for athletic purposes.

    Benefits are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount for the least expensive service that meets your medical needs. If your service is more costly than is Medically Necessary, you will be responsible for paying the difference between the Maximum Allowed Amount for the least expensive and the charge for the more expensive service. If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for the disease or injury, Benefits will be based on the least expensive method of treatment, prosthetic device, or Durable Medical Equipment that can meet the Member's needs. The Plan does not provide Benefits for replacement of Durable Medical Equipment and Prostheses due to being lost, stolen, or damaged due to weather.

23. Early Intervention Services. The Plan provides Benefits for the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with Members from birth to 36 months of age with an identified Developmental Disability and/or delay.

    Prior Approval is required. Speech, occupational and physical therapy services provided as part of Early Intervention Services do not apply to visit limits under those services. Early Intervention Services are limited to 50 visits per Member per Calendar Year.

24. Emergency Services. The Plan provides Benefits for emergency department screening and treatment received for Medical Emergencies

    If you need follow-up care after you are treated in an emergency department, you should call your PCP.

    If you are hospitalized, you or your Designee should call Health Options at 1-855-624-6463 (TTY/TDD: 711) within 48 hours or as soon as you can. However, if your attending emergency department Provider tells Health Options or your PCP within 48 hours that you have been hospitalized, then you do not need to call us. If you are unable to notify us, you may be responsible for any services that are determined to be not Medically Necessary.

    If you are admitted as an Inpatient to the Hospital from the emergency department, you will not need to pay your Out-of-Pocket Costs for that emergency department visit. You will be responsible for your In-Patient cost-sharing as described in your *Schedule of Benefits.*

Medically Necessary Emergency Services will be covered whether you get care from an In-Network or Out-of-Network Provider within the United States. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to the applicable cost-sharing (Deductible, Coinsurance or Copayments).

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method Health Options generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

Treatment received after your condition is stabilized is not Emergency Care. Treatment received outside of Emergency Ambulance Service and the Emergency Room is not Emergency Care and may require Prior Approval or Notification. If you continue to get care from an Out-of-Network Provider in the Service Area, Covered Services will be covered at the Out-of-Network level.

25. Eye Examinations. The Plan provides Benefits for one routine eye exam, including refraction, per Calendar Year to check all aspects of your vision for Members to the end of the month in which they turn age 19.

    The Plan does not provide Benefits for the fitting or purchase of eyeglasses or contact lenses, except as covered under "Eye Vision Hardware" (section 4.B.26)

    The Plan provides benefits, with no cost sharing, for visual acuity screening for children once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors. This is a preventive service as defined in section 2.H of this Agreement.

    Medical and surgical treatment of injuries and illnesses of the eye are Covered Services. Prior Approval may be required.

26. Eye Vision Hardware. The Plan provides certain Benefits for eyewear (either contact lenses or basic glasses and frames) once every 24 months, and other vision services (optional lenses and treatments) for Members to the end of the month in which they turn age 19.

    Additionally, the Plan provides certain Benefits for contact lenses or eyeglasses needed for all Members with the eye conditions indicated below:

    a. Post cataract surgery with an intraocular lens implant (pseudophakes).
    b. Post cataract surgery without lens implant (aphakes).
    c. Keratonconus.
    d. Post retinal detachment surgery.

    Eyewear includes standard plastic (CR39) eyeglass lenses with factory scratch coating at no additional cost (up to 55 mm); basic frames; and contact lenses.

    No Benefits are provided for deluxe or designer glasses or frames. No Benefits are provided for the replacement of lenses, frames or contacts.

27. Foot Care. The Plan provides Benefits for Medically Necessary podiatry services, including diabetic foot exam and systemic circulatory disease. Routine foot care is not covered. See Section 5 for more information on excluded foot care.

28. Freestanding Imaging Centers. The Plan provides Benefits for covered Diagnostic Services performed by Freestanding Imaging Centers. All services must be ordered by a Provider.

    Certain imaging services require Prior Approval. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

29. Hearing Care. The Plan provides Benefits for wearable Hearing Aids for covered Members to the end of the month in which they turn age 19. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered.

    Hearing Aids are considered Durable Medical Equipment. Benefits for Hearing Aids are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount for the least expensive service that meets

your medical needs. If your service is more costly than is Medically Necessary, you will be responsible for paying the difference between the Maximum Allowed Amount for the least expensive service and the charge for the more expensive service. No Benefits are provided for cochlear implants.

Benefits are available for Inpatient and Outpatient services to diagnose and treat ear disease and injury. The Plan does not provide Benefits for replacement of lost or stolen Hearing Aids. The Plan does not provide Benefits for replacement of Hearing Aids damaged due to weather.

30. Home Health Care Services. The Plan provides Benefits for home health care services when services are performed and billed by a Home Health Care Agency. These services are covered if hospitalization or confinement in a residential treatment facility would otherwise have been required. A Home Health Agency must submit a written plan of care order by a Provider to Health Options, and then provide the services approved by Health Options whether or not the patient is homebound.

    The home health care services covered by the Plan include:

    a. Visits by registered nurses and licensed practical nurses;
    b. Physician or nurse practitioner home and office visits;
    c. Visits by a registered physical, speech, occupational, inhalation, and dietary therapist;
    d. Supportive services, including prescription drugs, medical and surgical supplies, and oxygen, but only to the extent that such services would have been covered if you remained in the Hospital; and
    e. Visits by home health aides under the supervision of a registered nurse.

    Speech Therapy, Physical Therapy and/or Occupational Therapy visits are limited to 60 total visits per Member per Calendar Year.

31. Hospice Care Services. The Plan provides Benefits for Hospice Care to Members diagnosed as having a terminal illness by a Provider with a life expectancy of less than twelve months. The Hospice plan of care will focus on palliative rather than curative treatment for the terminally ill Member. The care approach is holistic and interdisciplinary. Your Provider and hospice medical director must certify that you are terminally ill and likely have less than twelve months to live. Your Provider must agree to care by the hospice Provider and must be consulted in the development of the care plan. The hospice Provider must keep a written care plan and provide it to Health Options upon request.

    Prior Approval is required.

32. Hospice Respite. The Plan provides Benefits for Hospice Respite Care for up to one 48-hour period, when Member is participating in Prior Approved Hospice Care, to allow the care giver of the Member receiving Hospice for relaxation. This Benefit is available once per lifetime of the Member receiving Hospice Care.

    Prior Approval is required.

33. Hospice Services - Inpatient. The Plan provides Benefits for Inpatient Hospice Care at an acute care Hospital or Skilled Nursing Facility. The same services are covered for Inpatient Hospice Care as are covered under Inpatient Hospital services (section 4.B.39).

34. Inborn Errors of Metabolism. The Plan provides Benefits for metabolic formula for special modified low protein food products. Such food products must be specifically manufactured for patients with diseases caused by Inborn Errors of Metabolism. This Benefit is limited to those Members with diseases caused by Inborn Errors of Metabolism.

35. Independent Laboratories. The Plan provides Benefits for Diagnostic Services ordered by a Provider and performed by Independent Laboratories.

36. Infant Formulas. The Plan provides Benefits for Medically Necessary amino acid-based elemental Infant Formula for Members two years of age or younger, without regard to the method of delivery of the formula. Coverage will be provided under this section when a Physician Provider has documented that the amino acid-based elemental infant formula is Medically Necessary, such that:

    a. The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and

    b. Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated.

In addition, coverage will only be provided to a Member under this section when a Physician Provider has diagnosed, and through medical evaluation has documented, one of the following conditions:

a. Symptomatic allergic colitis or proctitis;
b. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis;
c. A history of anaphylaxis;
d. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
e. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
f. Cystic fibrosis; or
g. Malabsorption of cow milk-based or soy milk-based infant formula.

Health Options may require that a Physician Provider confirm and document at least annually that the formula remains Medically Necessary.

The cost-sharing for formula is treated as Durable Medical Equipment for purposes of the *Schedule of Benefits*.

37. Infusion Therapy. The Plan provides Benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy Provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered as described in your *Schedule of Benefits*. Prior Approval is required.

Home-based infusion may save you money over facility-based infusion. Ask your Provider if home-based infusion is an appropriate option for you. Call Member Services at 855-624-6463 Monday-Friday, 8am-6pm, if you need assistance finding an in-network home-infusion Provider.

38. Inhalation Therapy. The Plan provides Benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

39. Inpatient Hospital Services. The Plan provides Benefits for the following Inpatient Hospital services:

a. Room and board, including general nursing care, special duty nursing, and special diets, in a semiprivate room;
b. Use of intensive care or coronary care unit;
c. Diagnostic Services;
d. Medical, surgical, and central supplies;
e. Physician services;
f. Nurse Practitioners;
g. Treatment services;
h. Maternity admissions;
i. Hospital ancillary services including but not limited to use of an operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services;
j. Phase I cardiac rehabilitation;
k. Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels unless approved by us for Medically Necessary accepted indications or as required by law. Any FDA treatment investigational new drugs are not covered unless approved by us for Medically Necessary accepted indications or as required by law;
l. Blood and blood derivatives;
m. Durable Medical Equipment, Prostheses, and Orthotic Devices; and
n. Newborn care, including routine well-baby care.

Prior Approval and/or a written plan of care may be required. The Plan provides Benefits for a private room if Medically Necessary and Approved by Community Health Options.

The Plan will stop providing Benefits for an Inpatient Stay at a Hospital after the earliest of:

a. Your discharge as an Inpatient;
b. Reaching any Benefit limits or maximums; and
c. You being notified by a Physician, appropriate Hospital staff, or Health Options that you are no longer eligible for continued Inpatient Stay at a Hospital.

40. Leukocyte Antigen Testing to Establish Bone Marrow Donor. The Plan provides Benefits for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability if the following requirements are met:

a. The Member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;

b. The testing must be performed in facility accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967; and
c. At the time of testing, the Member must complete and sign an informed consent form that authorizes the test results to be used for participation in the National Marrow Donor Program or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

Benefits are limited to one test per lifetime.

41. Massage Therapy. The Plan provides Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a covered Provider. A massage therapist is not a covered Provider.

42. Medical Care. The Plan provides Benefits for medical care and services including office visits, consultations, Hospital, Urgent Care and Skilled Nursing Facility visits, and pediatric services.

43. Medical Supplies. The Plan provides Benefits for medical supplies furnished by a Provider in the course of delivering Medically Necessary services. This Benefit does not apply to bandages and other disposable items that may be purchased without a prescription even if available by prescription, except for syringes which are Medically Necessary for injecting insulin or a drug prescribed by a Physician.

44. Mental Health and Substance Abuse. The Plan provides Benefits for Mental Health and Substance Abuse services when they are for the active treatment of Mental Health and Substance Abuse disorders. An established plan of treatment may be required. This includes Inpatient, Outpatient, and Day Treatment Program services for Mental Health and Substance Abuse when you receive them from a Provider.

If you receive services from a Community Mental Health Center or Substance Abuse Treatment Facility, services must be:

a. Supervised by a licensed Physician, licensed clinical psychologist, or licensed clinical social worker; and
b. Part of a plan of treatment for furnishing such services established by the appropriate staff member.

The Plan provides Benefits for only the following mental health and substance abuse treatment services:

a. Room and board, including general nursing;
b. Prescription drugs, biologicals, and solutions administered to inpatients;
c. Supplies and use of equipment required for detoxification and rehabilitation;
d. Diagnostic and evaluation services;
e. Intervention and assessment;
f. Facility-based professional and ancillary services;
g. Individual, group, and family therapy and counseling;
h. Medication checks;
i. Psychological testing; and
j. Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.

Outpatient visits for substance abuse conditions may be furnished during the acute detoxification stage of treatment or during stages of rehabilitation.

Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

45. Morbid Obesity. The Plan provides Benefits for surgery for an intestinal bypass, gastric bypass, or gastroplasty for treatment of Morbid Obesity.

Prior Approval is required. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

The Plan does not provide Benefits for weight loss medication.

46. Nutritional Counseling. The Plan provides Benefits for nutritional counseling when required for a diagnosed medical condition. Prior Approval is required after the 6th visit.

47. Obstetrical Services and Newborn Care. The Plan provides Benefits for pre-natal, delivery and post-partum care, care of a newborn and complications of pregnancy.

Routine newborn care does not include any services provided after the mother has been discharged from the Hospital. All other Plan provisions such as Deductible and Coinsurance, if applicable, will apply to the newborn if the mother is discharged and the newborn remains in the Hospital.

The Plan will not restrict Benefits for a mother or newborn child for any Hospital length of stay due to childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. This does not prohibit the mother or newborn from being discharged earlier should the attending Provider deem appropriate after consulting with the mother.

Home-birth

The Plan provides Benefits for home deliveries by a certified nurse midwife. Home birth services are covered when performed by a licensed Provider within the scope of the Provider's license.

48. Office Visits. The Plan provides Benefits for office visits to Providers.

Services rendered during an office visit, such as medical exams, management of therapy, injections, surgery and anesthesia, may be subject to additional charges beyond office visit Out-of-Pocket Costs.

Online Visits

When available in the Member's area, the Plan provides coverage that will include online visit services. Covered Services include a medical consultation using the internet via webcam, chat or voice.

The Plan does not cover communications used for: reporting normal lab or other test results, office appointment requests, billing, insurance coverage or payment questions, requests for referrals to Providers outside the online care panel, benefit precertification, physician to physician consultation.

Please refer to the "Telemedicine" provisions for additional or different services available.

49. Organ and Tissue Transplants. As described in this section, the Plan provides Benefits for Medically Necessary organ and tissue transplant procedures. You must receive Prior Approval from us before you are admitted for any transplant procedure. Your Provider will work with our registered nurses and Physician advisors to evaluate your condition and determine the Medical Necessity of a transplant procedure. Failure to receive Prior Approval prior to admission may result in a denial or reduction of Benefits.

Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

Covered transplants include: heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

No other organ or tissue transplant is covered. The Plan does not provide Benefits for any services related to a transplant that is not covered.

The Plan provides Benefits for organ and tissue transplant donors only if (1) the donor is a Member or the donor does not have similar Benefits available from another source, and (2) the recipient is a Member. When the donor is eligible for coverage under the Plan, the Plan provides Benefits for medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's expenses have been paid.

50. Orthotic Devices. The Plan provides Benefits for certain Orthotic Devices, including but not limited to orthopedic braces, back or surgical corsets, and splints.

The Plan does not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

51. Outpatient Services. The Plan provides Benefits for the following Hospital Outpatient, Federally Qualified Health Center and Rural Health Clinic services:

a. Medical exams;
b. Management of therapy;
c. Injections;
d. Emergency department services/emergency care;
e. Removal of sutures;
f. Application or removal of a cast;
g. Diagnostic Services;

h. Surgical services;
i. Anesthesia;
j. Removal of impacted or unerupted teeth;
k. Endoscopic procedures;
l. Blood administration;
m. Radiation Therapy; and
n. Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for these Benefits.
o. Outpatient educational programs. Please check with us to see if you are eligible for Benefits.

Cardiac rehabilitation Benefits are limited to 36 visits per cardiac episode per Member per Calendar Year. Prior Approval is required.

Pulmonary rehabilitation requires Prior Approval.

Speech Therapy, Physical Therapy, and Occupational Therapy Benefits are limited to 60 total visits per Member per Calendar Year.

52. Parenteral and Enteral Therapy. As required by Maine law, the Plan provides Benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

53. Prescription Drugs. The Plan provides Benefits for FDA-approved prescription drugs and medicines listed on Health Options' formulary and bought for use outside a Hospital. The prescription drug Out-of-Pocket Cost may vary depending on the tier that Health Options assigns to the drug. Please see your *Schedule of Benefits* for details.

Note: Your cost-sharing responsibilities will not be reduced by any discounts, rebates or other funds received by Health Options' designated Pharmacy Benefits Manager (PBM) from drug manufacturers, wholesalers, distributors, and/or similar vendors and or funds received by Health Options' designated PBM.

A copy of the current formulary is available online at www.healthoptions.org or you may request a copy of the formulary by calling Member Services at 1-855-624-6463 (TTY/TDD: 711). The inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

Specific prescription drugs (or the prescribed quantity of a specific drug) may require Prior Approval. More information about which drugs require Prior Approval is available at www.healthoptions.org. On the formulary, medications that require Prior Approval for coverage are marked accordingly.

Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Prescriptions must be used for their FDA-approved purpose unless Prior Approval for off-label use has been obtained. . Benefits are available for off-label use if a drug is recognized for treatment in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association policy. The plan provides Benefits for Medically Necessary services associated with the administration of the drug.

No Benefits are provided if the FDA has determined that a use is contraindicated.

54. Preventive Care and Well-Care Services. The Plan provides Benefits for certain preventive care and well-care services. Preventive Care Services shall meet the requirements as determined by federal and state law. Preventive Care is for adults and children that do not have symptoms of a medical condition for which services are being sought. Care required to treat a previously diagnosed medical condition will not be considered under the Preventive Care and Well-Care Services and will be subject to the Out-of-Pocket Costs described in the *Schedule of Benefits*, if a Covered Service. The determination of Preventive Care coverage by the Plan for services that meet the below criteria is based on the diagnosis and procedure codes submitted by your Provider. Services that are directly related to the performance of a Preventive Care Service are adjudicated under the Preventive Care Services Benefit (e.g. the drawing of blood associated with a Preventive Care lab test).

Preventive care services and items listed in sections 2.H are covered by the Plan with no Out-of-Pocket Costs for the Member when obtained In-Network. That means the Plan pays 100% of the Maximum allowable amount. These services are:

a. Services with an "A" or "B" rating from the United States Preventive Services Task Force;
b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;

c. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (includes diabetes screening and lead screening for children); and
d. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration (including annual gynecological exams and pap smears).

Preventive care that is not included in the four categories listed above will not be considered Preventive Care for the purposes of this Agreement and will be subject to Out-of-Pocket Costs described for the service provided in the *Schedule of Benefits*. You may call Member Services at 1-855-624-6463 (TTY/TDD: 711) for additional information about these services.

If a preventive care service or item described in this section:

a. Is billed separately (or is tracked as an individual encounter data separately) from an office visit, the Plan may impose Out-of-Pocket Costs with respect to the office visit.
b. Is **not** billed separately (or is tracked as an individual encounter data separately) from an office visit and the primary purpose of the office visit is for preventive care services or items, then the Plan will not impose Out-of-Pocket Costs with respect to the office visit.
c. Is **not** billed separately (or is tracked as an individual encounter data separately) from an office visit and the primary purpose of the office visit is **not** for preventive services or items, the Plan may impose Out-of-Pocket Costs with respect to the office visit.

Note: You may incur additional cost shares when services other than Preventive Care are rendered during a Preventive Care visit. Benefits will be based on the service code listed by your Provider.

Preventive Services are subject to change based on the recommendations described above. For the most up to date information and complete details on how Community Health Options administers Preventive Services coverage, visit www.healthoptions.org/Documents/PreventiveServices or call Member Services at 855-624-6463. Some examples of Preventive Services that are available at no Out-of-Pocket cost to you, when the criteria are met, include:

- Screening mammograms,
- Annual wellness exams,
- Blood pressure, diabetes, and cholesterol tests,
- Well-baby and well-child visits,
- Routine vaccinations, and
- Flu and pneumonia shots.

55. Prostate Cancer Screenings. The Plan provides Benefits to male Members aged 50 to 72 for a yearly prostate cancer screening including 1) digital rectal examination, and 2) prostate-specific antigen tests. To be covered by the Plan, such services must be recommended by the Member's PCP as Medically Necessary.

    Prostate cancer screenings will be subject to Out-of-Pocket Costs.

56. Radiation Therapy. The Plan provides Benefits for Radiation Therapy services for treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning. Prior Approval is required for oncology treatment.

57. Reconstructive Surgeries, Procedures, and Services. The Plan provides Benefits for reconstructive surgeries, procedures, and services, when considered to be Medically Necessary.

    Reconstructive surgeries, procedures, and services must meet at least one of the following criteria:

    a. Necessary due to Accidental Injury;
    b. Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury;
    c. Medically Necessary to restore or improve a bodily function;
    d. Necessary to correct a birth defect for covered Dependent children who have functional physical deficits; or
    e. Reconstructive breast surgery as described in section 4.B.9.

    Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not Covered.

58. Screening Mammograms. The Plan provides Benefits for annual screening mammograms for asymptomatic Members who are women 40 years of age and older for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast, with no cost-sharing.

The Plan also provides Benefits for additional radiological procedures recommended by a Provider when the initial screening mammogram results are not definitive. Additional radiological procedures following an initial screening are considered "Diagnostic" and are subject to cost-sharing. Mammograms ordered to monitor a diagnosed condition are not screening mammograms and will be subject to cost-sharing.

59. Second Opinions. The Plan provides Benefits for second opinions when provided by a Plan Provider with no practice association with the original Provider. Prior Approval is required for second medical/surgical opinions provided by a Non-Plan Provider.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

60. Skilled Nursing Facility Services. The Plan provides Benefits for Inpatient Skilled Nursing Facility services with Prior Approval. The Plan does not cover Custodial Care.

    Benefits are limited to 150 days per Member per Calendar Year.

61. Sleep Studies. The Plan provides Benefits for Medically Necessary sleep studies. The Benefit is limited to a maximum of two sleep studies per Calendar Year. Prior Approval is required.

    Home-based sleep studies may save you money over facility-based sleep studies. Ask your Provider if a home-based sleep study is an appropriate option for you. Call Member Services at 855-624-6463 Monday-Friday, 8am-6pm, if you need assistance finding an in-network home sleep study Provider.

62. Speech Therapy, Physical Therapy, Occupational Therapy and Habilitative Services. The Plan provides Benefits for short-term speech, physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed professional acting within the scope of his or her license. To be Covered Services, services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

    Speech Therapy, Physical Therapy and Occupational Therapy Benefits are limited to 60 total visits per Member per Calendar Year.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

    Except as covered in section 4.B.23, no Benefits are provided for speech therapy for deficiencies resulting from intellectual disabilities or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

    Unless explicitly stated in this Agreement, no Benefits are provided, even if ordered by your physician or supervised by skilled personnel, for: on-going or life-long exercise and education programs intended to maintain fitness; voice fitness or to reinforce lifestyle changes; voice therapy; vocal retraining; preventive therapy or therapy provided in a group setting; or educational reasons.

63. Surgical Services. The Plan provides Benefits for Medically Necessary surgical procedures on an Inpatient or Outpatient basis, including services of a surgeon, Specialist, anesthesiologist, or anesthetist, and for preoperative and postoperative care.

    For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Health Options surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Member Services at 855-624-6463. Prior Approval is required.

64. Telemedicine Services. The Plan provides Benefits for telemedicine services if the service would be covered under the Plan were it provided through in-person consultation between the Member and a Provider. Coverage for services provided through Telemedicine must be determined in a manner consistent with coverage under the Plan for services provided through in-person consultation with a Provider.

    Telemedicine services are limited to the use of HIPAA-compliant, real-time interactive audio, video, or electronic media communications as a substitute for in-person consultation with Providers.

    Out-of-Pocket Costs for telemedicine services are the same as the Out-of-Pocket Costs for the same type of service if it had been provided through an in-person consultation.

65. Tobacco/Smoking Cessation. The Plan provides Benefits for FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) with no Out-of-Pocket costs when prescribed by a health care Provider (limited to two 90-day treatment regimens for prescription medications per Member per Calendar Year). To be eligible for Benefits, prescription and over-the-counter medications must be prescribed by your Provider for tobacco cessation purposes.

The Plan provides Benefits for tobacco cessation programs, follow-up education, counseling, and completion of a Health Options approved smoking cessation program. This is a preventive service as defined in section 2.H of this Agreement.

For the current list of approved programs visit www.healthoptions.org.

5. EXCLUSIONS FROM BENEFITS

The Plan will not provide Benefits for: (1) anything that is not Medically Necessary; (2) anything provided before or after the dates coverage is effective (except as required by law); (3) non-Covered Services and any services, items, or charges related to non-Covered Services; (4) services, supplies, and any charges from a non-Provider or an excluded Provider; (5) items and services furnished outside the United States; and (6) services and supplies to the extent that you do not have to pay or you have the right to recover expenses through a federal, state, county, or local law (even if you waive or do not assert your rights).

The following list of services and supplies specifies not Covered Services and the Plan will not provide Benefits for them. These exclusions are in addition to other exclusions listed in this Agreement. If you pay for a non-Covered Service, it will not count toward your Out-of-Pocket Cost limits.

1. Abortions. The Plan does not provide Benefits for abortions for which Federal funding is not allowed in accordance with the Affordable Care Act, namely all abortions except in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.

2. Acts of War, Riots or Illegal Acts. Benefits are not provided for any illness or injury that is a result of war, declared or undeclared, or any act of war. Benefits are not provided for a condition resulting from direct participation in a riot, civil disobedience, being intoxicated or being under the influence of an illegal substance unless administered on the advice of a physician, nuclear explosion, nuclear accident or engaging in an illegal occupation.

3. Administrative Examinations or Services. The Plan does not provide Benefits for physical examinations and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

4. Alternative and Complementary Treatment and Therapy. The Plan does not provide Benefits for alternative or complementary treatments and therapies for which clinical effectiveness has not been proven as determined by Community Health Options' ("Health Options") Chief Medical Officer. These include, but are not limited to:

   a. Acupuncture,
   b. Biofeedback,
   c. Holistic medicine,
   d. Homeopathy,
   e. Hypnosis,
   f. Aromatherapy,
   g. Reiki therapy,
   h. Massage therapy,
   i. Herbal, vitamin or dietary products or therapies,
   j. Naturopathy,
   k. Thermography,
   l. Orthomolecular therapy,
   m. Contact reflex analysis,
   n. Bioenergial synchronization technique, and
   o. Iridology.

   If you receive Covered Services from a licensed Provider of alternative or complementary treatment, and that Provider is operating within the scope of his or her license, those Covered Services will be covered according to your *Schedule of Benefits.*

5. Artificial Heart Devices. Artificial or mechanical hearts or heart assist devices are not covered as a Benefit. This exclusion does not include pacemakers or defibrillators. In addition, services and supplies for treatment of a heart condition while such devices remain in place are also not covered. The only exception is for left ventricular assist devices that are being used temporarily while awaiting heart transplant.

6. Charges Above the Maximum Allowable Amount. No Benefits are provided for charges above the Maximum Allowable Amount determined by Community Health Options.

7. Commercial Diet Plans and Programs. The Plan does not provide Benefits for commercial diet plans or weight loss programs except as specifically approved by Health Options and covered under this Agreement.

   This exclusion does not apply to Medically Necessary treatments for morbid obesity. See section 4.B.45.

8. Cosmetic Services. Except for reconstructive services described under section 4.B.57, the Plan does not provide Benefits for Cosmetic Services.

9. Court Ordered Testing or Care. The Plan does not provide Benefits for court ordered testing or care, unless the service is Medically Necessary and Approved by Health Options.

10. Custodial Care. The Plan does not provide Benefits for services, supplies, or charges for Custodial Care, convalescent care or rest cures.

11. Dental Care. Except as covered under section 4.B, the Plan does not provide Benefits for dental services, including but not limited to dental surgery, dental implants, or Orthognathic Surgery. Treatment of congenitally missing, malpositioned, or super numary teeth, even if part of a congenital anomaly is not covered except as stated in the Covered Services section or as required by law.

12. Domiciliary Care. The Plan does not provide Benefits for Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

13. Drugs (Medications). Unless specifically stated otherwise in this Agreement, the Plan does not provide Benefits for the following:

    - Administration Charges for the administration of any drug except for covered immunizations as approved by Health Options or the PBM
    - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice
    - Charges for delivery of prescription drugs
    - Drugs given at the Provider's office or facility drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by a Doctor. This exclusion does not apply to drugs used with diagnostic service, drugs given during chemotherapy in the office, or drugs covered under the Medical Supplies benefit.
    - Drugs that do not need a prescription by federal law, except for injectable insulin. This exclusion does not apply to over the counter drugs that we must cover under federal law when recommended by the USPSTF and prescribed by a physician.
    - Drugs prescribed or refilled that are over quantity limits set by Health Options
    - Mail service programs other than the Health Options Approved or PBM's Home Delivery Mail Service unless coverage is required by law
    - Drugs that are not included on the formulary
    - Drugs that are not approved by the FDA
    - Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic
    - Legend (prescription) drugs that are not deemed Medically Necessary
    - Experimental or Investigational drugs
    - Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine
    - Therapeutic devices or appliances
    - Anorectic or any other drugs used for the purpose of weight control
    - Any drug used for cosmetic purposes
    - Weight loss drugs
    - Drugs filled without a prescription
    - Drugs related to infertility services
    - Drugs prescribed for impotence, erectile dysfunction, and/or sexual dysfunction
    - Prescription refills in excess of the number specified by the prescribing Provider
    - Prescription refills dispensed more than one year from the date of the original order
    - Any portion of a drug for which Prior Approval or step therapy is required but not obtained
    - Any drug obtained before the Member became covered under the Plan
    - Any drug obtained after the Member's coverage has ended
    - Any prescription drugs that are lost, stolen, spilled, spoiled, or damaged

14. Durable Medical Equipment/Medical Supplies. The Plan does not provide Benefits for spare or back-up or other Durable Medical Equipment or Medical Supplies unless specifically stated. For a full list of excluded equipment and supplies, visit www.healthoptions.org or contact Member Services.

15. Erectile or Other Sexual Dysfunction. The Plan does not provide Benefits for any drugs, supplies, services, or equipment for the treatment or correction of Sexual Dysfunction for male or female sexual problems. This exclusion includes sexual therapy and counseling, penile prostheses or implants, vascular or artificial reconstruction, prescription drugs, and

all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

16. Experimental or Investigational Services. The Plan does not provide Benefits for any drugs, supplies, services, or equipment that are Experimental or Investigational as defined in this Agreement. The Plan does not provide Benefits for costs related to the provision of Experimental or Investigational drugs, supplies, services, or equipment. These exclusions do not apply when coverage is required by law.

    The Plan does not provide Benefits for laboratory tests that have not been approved by the FDA. The Plan does not provide Benefits for the Anser IFX test.

    Statement for New Technology: Health Options recognizes the need to evaluate coverage of new clinical technology by the Health Options health plans. Health Options reviews requests to evaluate new technologies from a variety of sources. If you would like a copy of Health Options' procedure for reviewing new technology, please call Member Services at 1-855-624-6463.

17. Food or Dietary Supplements. The Plan does not provide Benefits for nutritional or dietary supplements unless covered in this Agreement or required by law. This exclusion includes, but is not limited to, over the counter nutritional formulas and dietary supplements.

18. Free Care. The Plan does not provide Benefits for services for which you have no legal obligation to pay in the absence of this or like coverage.

19. Genetic Testing and Counseling. The Plan does not provide Benefits for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition.

20. Government Services and Supplies. When services and supplies are provided by a facility owned or operated by federal, state, county, or local government, Benefits are not provided under the Plan. The Plan does not provide Benefits for services and supplies (1) provided by the U.S. Department of Veterans Affairs to veterans for a service-connected disability, or (2) provided by a uniformed services facility (unless you are a military dependent or retiree). The Plan does not provide Benefits for care required while incarcerated in federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

21. Gym or Spa Memberships. The Plan does not provide Benefits for health spas, gym memberships, health club memberships, exercise equipment, physical fitness or personal training, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Provider.

22. Hearing Care. The Plan does not provide Benefits for routine hearing examinations except for screening Members under the age of 19 years or when related to injury or disease and otherwise covered under this Agreement. Please see section 4.B.29 for Benefits for Hearing Aids.

23. Infertility; Surrogacy. The Plan does not provide Benefits for fertility drugs, Diagnostic Services, procedures, treatment, or other services or costs related to Infertility. This exclusion also applies to drugs used to enhance fertility.

    The Plan does not provide Benefits for services, supplies, or costs associated with surrogacy pregnancies. The Plan does not provide Benefits for the bearing of a child by another woman for an infertile couple. If the woman bearing the child is a Health Options Member benefits will be applied according to the woman's Plan.

    The Plan does not provide Benefits for artificial insemination (AI) services or assisted reproductive technologies (ART) services or the diagnostic tests and Drugs to support AI or ART services. Excluded ART services include, but are not limited to, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

24. Leased Services and Facilities. The Plan does not provide Benefits for any health care services or facilities that are not regularly available at the Provider that you go to, that the Provider must rent or make special arrangements to provide, and that are billed independently.

25. Maintenance and Regression. The Plan does not provide Benefits for Maintenance Services, treatments, or therapy. The Plan does not provide Benefits for services performed solely to prevent regression of functions for an illness, injury or conditions which is resolved or stable. This exclusion does not include Maintenance Medications. This exclusion does not apply to Habilitative Services.

26. Miscellaneous Expenses; Extra Services; Missed Appointments; Travel Costs.

The Plan does not provide Benefits for Provider charges to provide required information to process a claim or application for coverage. The Plan does not provide Benefits for Appeal costs other than costs Health Options must pay under law.

The Plan does not provide Benefits for extra services from your Provider. These extra services are sometimes called "concierge services." These extra services may include:

i. Telephone access to your Provider 24 hours a day, 7 days a week;
ii. Having a Provider accompany you to appointments with Specialists;
iii. Guaranteed same-day appointments when not Medically Necessary; and
iv. Making travel arrangements for you.

The Plan does not provide Benefits for fees you are charged for missed appointments.
The Plan does not provide Benefits for any travel costs, whether or not the travel is recommended by a Provider.

27. Non-emergency Ambulance Services. Except as stated in the Covered Services section of this Agreement, the Plan does not provide Benefits for Ambulance usage when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. This exclusion includes, but is not limited to, trips to a physician's office, clinic, morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered to transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

28. Non-prescriptive Birth Control. The Plan does not provide Benefits for non-prescriptive birth control preparations unless the contraceptive method is only available over-the-counter. To get reimbursed for an over-the-counter contraceptive method, you Provider must provide you with a prescription to submit with your reimbursement. For more information about the reimbursement process, contact Member Services at 855-624-6463.

29. Orthognathic Surgery. The Plan does not provide Benefits for Orthognathic Surgery, except as covered under section 4.B.57.

30. Orthotic Devices; Shoe Inserts. The Plan does not provide Benefits for Orthotic Devices unless specified in Section 4.B. The Plan does not provide Benefits for shoe inserts except in certain cases for diabetic care.

31. Other Provider Charges. The Plan does not provide Benefits for physician or other practitioners' charges for consulting with Members by telephone, fax, e-mail or other consultation or medical management service not involving direct care with the Member. This includes, but is not limited to, the following: surcharges for furnishing and/or receiving medical records and reports; charges for doing research with Providers not directly responsible for your care; charges that are not documented in Provider records; charges for an outside laboratory or shop for services in connection with an order involving devices (e.g. prosthetic, orthotic) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician; and charges related to membership, administrative, or access fees by physicians or other Providers (e.g. education brochures, providing test results to Members).

32. Over the Counter Equivalents. The Plan does not provide Benefits for Drugs, devices, products or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply unless specifically stated as a Covered Service in this Agreement or as required by law.

33. Personal Comfort and Convenience. The Plan does not provide Benefits, including when provided in conjunction with Hospice Care, for any personal comfort or convenience items, including but not limited to homemaker services, television rentals, television service, newspapers, telephones, telephone service, or guest services. No Benefits are available for food services, meals, formulas and supplements other than listed in the Covered Services section. No Benefits are available for services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement of other legal services. Services provided by volunteers are not covered.

34. Personal Enrichment and Lifestyle Services. The Plan does not provide Benefits for any of the following services or any services relating to:

    a. Sensitivity training;
    b. Codependency;
    c. Adult Children of Alcoholics (ACOA);
    d. Pain control (except as required by law for Hospice Care);
    e. Recreational or social programs;
    f. Sports camps and other camps;
    g. Life coaching;
    h. Religious counseling;
    i. Employment counseling;
    j. Sex therapy;
    k. Encounter groups;
    l. Self-help training or other forms of non-medical self-care;
    m. Vocational training;
    n. Educational programs except those provided in this Agreement;
    o. Marriage, relationship, guidance and career counseling; or
    p. Relaxation activities.

35. Physical and Occupational Therapy. The Plan does not provide Benefits for treatment such as massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. Please see section 4.B.62.

    No Benefits are provided for hippotherapy; prolotherapy or recreational therapy.

36. Preventive Care. The Plan does not provide Benefits for preventive care and well-care services, unless otherwise stated in this Agreement in Sections 4.B and 2.H.

37. Private Duty Nursing. The Plan does not provide Benefits for private duty or block nursing services. Skilled nursing visits greater than two (2) hours per day are not covered. Block nursing to monitor or provide nursing coverage greater than two (2) hours per day is not covered.

38. Prostheses. The Plan does not provide Benefits for dental prostheses. The Plan does not provide Benefits for prosthetic devices to replace, in whole or in part, an arm or a leg, that are designed exclusively for athletic purposes. Covered prostheses described in section 4.B.8 and 4.B.22 are Covered under the Plan. No other prostheses are covered.

39. Refractive Eye Surgery. The Plan does not provide Benefits for refractive eye surgery, such as radial keratotomy or laser surgery, for vision conditions that can be corrected by glasses, contact lenses, or means other than surgery.

40. Relatives or Volunteers. The Plan does not provide Benefits for any services or supplies provided to you by immediate family members or step-family members. Services performed by volunteers are not covered, except as specifically provided in this Agreement.

41. Research. The plan does not provide Benefits for examinations related to research screening.

42. Reversing Voluntarily Induced Sterility. The Plan does not provide Benefits for services to reverse voluntarily induced sterility.

43. Routine Circumcisions. We do not provide Benefits for routine circumcisions.

44. Routine Foot Care. The Plan does not provide Benefits for routine foot care. This exclusion applies to, but is not limited to, cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to: cleaning and soaking the feet; applying skin creams to care for skin tone; or other services that are given when there is not an illness, injury or symptom involving the foot.

45. Services from Ineligible Facilities. The Plan does not provide Benefits for care or services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution. The Plan does not provide Benefits for services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. No Benefits are available for wilderness camps.

46. Services from Unlicensed or Ineligible Providers. The Plan does not provide Benefits for services received from Providers that are not licensed by law to provide Covered Services. Examples of such Providers may include, but are not

limited to, masseurs or masseuses (massage therapists) and physical therapist technicians. The Plan does not provide Benefits for services provided by any Provider not listed as an eligible Provider in this Agreement.

47. Services Received Outside of the United States. The Plan does not provide Benefits for Services received outside of the United States including Emergency Services. If you need coverage outside the United States, you should purchase travel medical insurance.

48. Shock Wave Treatment. The Plan does not provide Benefits for extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions unless in conjunction with an active course of treatment.

49. Spider Veins. The Plan does not provide Benefits for treatment of telangiectatic dermal veins (spider veins) by any method.

50. Spinal Decompression Devices. The Plan does not provide Benefits for spinal decompression devices including, but not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

51. Surgical Treatment of Certain Foot Conditions. The Plan does not provide Benefits for surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, or hyperkeratoses.

52. Temporomandibular Joint Syndrome ("TMJ"). The Plan does not provide Benefits for services for the evaluation, diagnosis, or treatment of TMJ, whether medical or surgical.

53. Vision Care. The Plan does not provide Benefits for vision care or eye examinations except as described in section 4.B. The Plan does not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. No Benefits are provided for deluxe or designer glasses or frames. No Benefits are provided for safety glasses and accompanying frames.

    Except as provided under section 4.B, the Plan does not provide Benefits for the prescription, fitting, or purchase of glasses or contact lenses.

54. Workers' Compensation. The Plan does not provide Benefits for services, supplies, or equipment for work-related illness, injury or disability that is due to an occupational disease for those with coverage under the workers' compensation laws or other programs of similar nature. If Health Options pays for services that are covered under workers' compensation, we reserve the right to recover payment from the Provider and/or the liable party.

    If, under State law, you are allowed to waive all workers' compensation coverage, this exclusion will not apply to the extent you waive workers' compensation coverage.

6. BENEFIT DETERMINATIONS, PAYMENT, AND CLAIMS

A. Benefit Determinations

The Plan, or a person or entity working on behalf of the Plan, will administer your Benefits and determine your Benefits in accordance with the terms of this Agreement. For Claim Denials, your Explanation of Benefits is your Notice of Adverse Benefit Determination. Other Adverse Benefit Determinations are described in section 2.F.4.

If you disagree with a determination made by the Plan, you may submit complaints and Appeal the decision as described in section 8.

B. Payment for Provider Services

1. Plan Providers

   If your claim from a Plan Provider is approved, the Plan will pay Benefits directly to the Plan Provider. Except for your Out-of-Pocket Costs, if applicable, you are not required to pay any balances to the Plan Provider until the Plan determines what it will pay.

   If you receive services from a Plan Provider that are not Covered Services, you will be responsible for the cost of those non-Covered Services. If a Plan Provider, who is licensed to perform alternative or complementary treatment and therapy, who is operating within the scope of his or her license and provides services that are listed as Covered Services, your cost-sharing responsibility is outlined in the *Schedule of Benefits*.

2. Non-Plan Providers

   If you receive Covered Services from a Non-Plan Provider, your cost-sharing will be higher, as described in the Out-of-Network portion of your *Schedule of Benefits*. **It is your responsibility to ensure the Providers you receive services from are in the Health Options Network.** If the Plan approves your claim for payment of services rendered by a Non-Plan Provider, the Plan will pay Benefits up to the Maximum allowable amount. We will pay Benefits directly to you or to the Non-Plan Provider.

   Charges above the Maximum allowable amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Plan Provider chooses to bill you. This means you may have financial responsibility greater than the cost-sharing described on your *Schedule of Benefits*. This is sometimes referred to as Balance Billing. Before you receive a service, you may call Community Health Options ("Health Options") toll-free at 1-855-624-6463 (TTY/TDD: 711) to learn the network status of the provider. If we deny your claim, you have the right to appeal our decision by following the steps in section 8. For Medical Emergency services rendered by a Non-Plan Provider, the Plan will provide Benefits at Plan Provider Out-of-Pocket Costs based on the Maximum allowable amount, as determined by us, for the services received.

C. Out-of-Pocket Costs

1. Copayments and Coinsurance

   You may have some responsibility for the cost of Covered Services under this Agreement and the *Schedule of Benefits*. Your responsibility may come in the form of Copayments and Coinsurance. These should be paid directly to the Provider. If you have Coinsurance responsibility, you will pay your Coinsurance percentage based on the Provider's discounted or negotiated charges with Health Options, if any.

2. Deductible

   Members may be responsible for paying a yearly Deductible amount described in each Member's *Schedule of Benefits*. Each Calendar Year, before the Plan pays Benefits for many Covered Services, Members must pay the applicable Deductible. Expenses for non-Covered Services will not apply to the Deductible. Copayments do not apply to the Deductible.

   a. Family Deductible. Under family coverage, once any one Member of the family meets the Individual Deductible for the Calendar Year, services for that Member are subject to any applicable coinsurance. Remaining family members individually or collectively must meet the remaining amount of the full Family Deductible. Once the full Family Deductible is met, services for all covered family members are subject to applicable coinsurance until the Out-of-Pocket Limit, described in section 6.C.3, is reached. The full Family Deductible is two times the Individual Deductible as described on your *Schedule of Benefits*.

b. One Deductible for a Common Accident. Under family coverage, if two or more family members are injured in the same Accident, only one Deductible will apply for all Covered Services resulting from that Accident during a Calendar Year.

3. Out-of-Pocket Maximum

Member annual Out-of-Pocket Costs for Copayments, Coinsurance, and Deductibles may be limited for Benefits that are "Essential Health Benefits". This is referred to as your Out-of-Pocket Maximum. Please see the *Schedule of Benefits* for details on your Out-of-Pocket Maximum and any Covered Services that do not apply to the Out-of-Pocket Maximum. Adult Vision Exams for Members 19 years of age and older are not "Essential Health Benefits" and do not accumulate toward your Out-of-Pocket Limits. **Charges from Non-Plan Providers above the Maximum allowable amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Plan Provider chooses to bill you. This means you may have financial responsibility greater than the cost-sharing described on your *Schedule of Benefits*.**

a. Family Out-of-Pocket Limit. Under family coverage, once any one Member of the family meets the Individual Out-of-Pocket Maximum for the Calendar Year, the Plan pays 100% of the Maximum allowable amount for Covered Services for that Member. Remaining family members individually or collectively can meet the remaining amount of the full Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, the Plan pays 100% of the Maximum allowable amount for Covered Services for all Members covered under the family policy. **Charges from Non-Plan Providers above the Maximum allowable amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Plan Provider chooses to bill you. This means you may have financial responsibility greater than the cost-sharing described on your *Schedule of Benefits*.**

4. Benefit Maximums

Benefits that are "Essential Health Benefits" as described by the Patient Protection and Affordable Care Act may not have annual or lifetime dollar limits. Any Benefit limitations are described in your *Schedule of Benefits*.

5. Plan Providers vs. Non-Plan Providers

Please note that your Out-of-Pocket Costs for Covered Services may be higher when Covered Services are provided by a Non-Plan Provider, or "out-of-network". This difference is described in more detail in your *Schedule of Benefits*. Under Maine law, the benefit level differential for Covered Services provided by a Plan Provider and a Non-Plan Provider cannot be more than 20%. When you receive services for a Medical Emergency, your Out-of-Pocket Costs will be at the Plan Provider level whether you see a Plan Provider or a Non-Plan Provider.

6. Third-Party Payment of Out-of-Pocket Costs

There may be instances where someone other than the Member pays the Member's Out-of-Pocket Costs under this Agreement. This is sometimes called "third-party payment of Out-of-Pocket Costs."

Members' family members, Designees, and legal representatives may pay Out-of-Pocket Costs on behalf of Members. Ryan White HIV/AIDS Programs, Indian tribes, tribal organizations, urban Indian organizations, and state and federal and local government programs may also pay Out-of-Pocket Costs on behalf of Health Options Members.

A Member may not have a Provider, pharmaceutical company, or other commercial health care entity pay for Out-of-Pocket Costs on behalf of a Member. Should a Provider pay the Member's Out-of-Pocket Costs on behalf of a Member for the service, the Plan will not be responsible for payment towards the service.

D. Claims (Proof of Loss) Procedures

1. Claims Generally

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.

Time Limits for Post-Service Claims: Health Options must receive a claim within 120 days after receiving a service or item covered by the Plan or as soon as reasonably possible after the 120 days if it is not reasonably possible to submit notice within the 120 days. A claim sent to Community Health Options at 150 Mill St, 3rd Floor, Lewiston, ME 04240, or to any authorized agent of Health Options, with information sufficient to identify the Member, shall be deemed notice to Health Options.

You may obtain a medical or prescription drug claim form at www.healthoptions.org or by calling Member Services at 1-855-624-6463 (TTY/TDD: 711). The form will include instructions on what information you will need to submit to the Plan so that the Plan can make a decision on the claim. Please return the completed claim form along with copies of any receipts or invoices to the address on the form.

If we do not furnish these forms to you within 15 days after we receive your request, you may meet the proof requirements by giving us a written statement of the nature and extent of the claim within 120 days after the service is rendered.

Benefits will be paid to the Member who received the services for which a claim is made unless the Member is a minor. In this case, Benefits will be paid to the parent or custodian with whom the minor resides. The Member may authorize Health Options to pay Benefits directly to the Provider who charged for the service subject to the claim.

Any payment made by Health Options in accordance with the terms of this Agreement will discharge Health Options from all further liability to the extent of such payment.

2. Payment Limits

The Plan limits what it will pay for Covered Services not provided by a Plan Provider. The most the Plan will pay is the Maximum allowable amount. **You may have to pay the balance if the claim is for more than the Maximum allowable amount even if you have met your Out-of-Network Out-of-Pocket Maximum.** The Plan will pay Benefits within 30 days after receipt of the clean claim and proof supporting the claim.

7. OTHER COVERAGE

A. Other Insurance Coverage – Generally

If you receive services that are covered by the Plan and that are also covered by another payment source, your Benefits will be coordinated with the other payment source. This is called coordination of benefits ("COB"). Your Benefits may also be subject to something called "subrogation." Both of these items are explained below. The purpose of COB and subrogation is to prevent duplicate payment for the same service. This section does not provide coverage for any service or supply that is not expressly covered under this Agreement, nor increase the level of coverage provided under this Agreement.

B. Coordination of Benefits

Benefits under this Agreement and the *Schedule of Benefits* will be coordinated to the extent permitted by law with other types of insurance coverage that pay for health care services and supplies. These other types of coverage may include:

- Auto insurance;
- Homeowners' insurance;
- Government benefits;
- Medicare; and
- Health plans ("Health Plans"), including, group and non-group health insurance contracts, health maintenance organization plans, nonprofit medical or hospital service corporation plans, and self-insured plans.

When there is COB, it will be based upon the Plan Maximum Allowed Amount for any service that is covered at least in part by any of the plans involved. If a Provider is paid under a capitation arrangement, COB will be based on the reasonable value of such services.

When a Member is covered by more than one Health Plan, one plan will be considered primary. The primary plan pays benefits first as though there was no other coverage. The benefits of secondary and tertiary plan(s) are determined after those of the primary plan. Secondary and tertiary plan benefits may be reduced by the primary plan's benefit and capped at the primary plan's maximum allowed amount. To the extent required by law, when a Member is covered by more than one Health Plan, payments made by the primary plan, payments made by the Member, and payments made from a health savings account or similar fund for benefits covered under the secondary plan will be credited toward the deductible of the secondary plan.

1. <u>COB Rules for Health Plans</u>

   Community Health Options ("Health Options") follows the guidelines established by the National Association of Insurance Commissioners (NAIC) in determine primacy between two or more health plans. If both this Agreement and the other Health Plan(s) contains a COB clause allowing the COB with this Agreement, Health Options will determine benefit payments by using the first of the following rules that applies:

   a. <u>Non-Dependent/Dependent</u>: The benefits of the contract that covers the person as an employee or subscriber will be primary before the benefits of the contract that covers the person as a dependent.
   b. <u>Dependent Children with Parents Not Legally Separated or Divorced</u>: Where both parents carry insurance, the child's primary coverage is determined according to the birth date rule if both carriers apply it. The birth date rule states that the plan covering the biological parent with the earliest birth date (month and day) in the calendar year is primary. If parents share the same birthday, the plan that has covered the parent longest is the primary plan. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this Agreement will determine the order of benefits.
   c. <u>Dependent Children with Parents Legally Separated or Divorced</u>: Where a child has parents who are divorced or legally separated, coverage for children is determined first by the divorce decree stating who is responsible for health care coverage. If the parent with responsibility has no health care coverage for the dependent child but that parent's spouse does, that parent's spouse's plan is the primary plan. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree. If coverage is not ordered in the divorce decree, then the parent with legal custody is primary. If both parents are responsible for the health care coverage and neither parent has primary custody, then the birth date rule is applied.
   d. <u>Primacy for Dependent Child of Non Parent</u>: For a dependent child covered under more than one plan of individuals who are not the parents of the child, primacy is determined by the Birth Date Rule, and Primacy for

Children of Divorce, as applicable, as if those individuals were parents of the child. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the Length of Coverage Rule applies and the plan that covered the person for the longer period of time is the primary plan.

e. Active/Inactive Employee: The Benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other Health Plan does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule (f) below applies.

f. COBRA or Continuation of Coverage: If a person whose coverage is provided under the right of continuation pursuant to COBRA or another Federal or State law is also covered by another contract, the Benefits of the contract covering the person as an employee, Member, or Subscriber, or as the Dependent of an employee, Member, or Subscriber, will be primary. The Benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule (f) below applies.

g. Length of Coverage Rule: If none of the above rules determines the order of Benefits, the Benefits of the contract that has covered the employee or Subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

h. Unable to determine order of benefits: If none of the preceding rules successfully determines the order of benefits, the Health Options allowable expenses shall be shared equally between the plans.

With respect to COB, Health Options may exercise its rights to carry out COB without providing notice to, or obtaining consent from, Members. Health Options may share information with another insurance company, rendering provider, or party to determine COB and take steps to recover the Plan's excess payment from another party or pay another party for its excess payment. Health Options reserves the right to suspend payment on a claim when the Plan is secondary until the Provider has submitted the claim to the primary plan and the primary plan has either paid or denied the claim. Nothing in this Agreement shall be interpreted to limit Health Options' right to use any remedy provided by law to enforce Health Options' rights to COB under this Agreement.

1. COB for Workers' Compensation, Government Benefits, and Other Insurance Coverage

   If Health Options pays Benefits for services for an illness or injury covered under workers' compensation or a similar program, or a government benefit, to the extent allowed by law Health Options may recover its expenses from Providers Health Options pays or from one or more third parties.

   For Members who are entitled to benefits under the medical payment benefit of another insurance policy (e.g., auto, homeowners'), that policy will be responsible for coverage with respect to a covered loss under that policy. All payments for services provided by the Plan to Members that are covered under any such medical payment policy or benefit are payable to Health Options.

2. Medicare

   If you are eligible for Medicare Part A, you must contact Member Services and let us know. You may remain an enrolled Member under the Plan even if you are enrolled in Medicare. To the extent allowed by law, your Benefits under the Plan will not duplicate any benefits that you receive under Medicare Part A or Part B regardless of whether you actually exercise your rights to Medicare Part A or Part B coverage

C. Subrogation

When a third party is legally responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When we provide Benefits for treatment of such injury or illness, we have the right to recover, on a just or equitable basis, from any such payment (whether or not such payment is for medical expenses) up to 100% of the Benefit we paid. We also have subrogation rights against your other insurance coverage provider, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy. We reserve the right to recover from a Member up to 100% of the value of Benefits provided or paid for by the Plan when a Member has been, or could have been, reimbursed for the cost of care by a third party. If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services. Nothing in this Agreement shall be interpreted to limit Health Options' right to use any remedy provided by law to enforce Health Options' rights to subrogation under this Agreement. Before we will enforce our subrogation rights, we will first obtain your prior written approval.

D. Cooperating with Health Options

As a Member under the Plan, you agree to cooperate with us in exercising our rights of subrogation and COB under this Agreement. Health Options agrees that subrogation payments will be made on a just and equitable basis. Your cooperation may include:

- Notifying us of any possible legal action or claim that may implicate Health Options' subrogation or COB rights;
- Providing us with any information and documents that we request;
- Assigning to Health Options payments that you receive for services paid by Health Options;
- Signing documents deemed necessary by Health Options to protect its subrogation and COB rights, including, but not limited to, providing Health Options with your prior written approval of Health Options enforcing its subrogation rights; and
- Not taking any action that would impede Health Options' subrogation or COB rights.

If you do not cooperate with Health Options as provided in this section, you may be liable to Health Options if Health Options needs to enforce its rights. You may also be liable for Health Options' costs and reasonable legal fees.

8. APPEALS AND COMPLAINTS

A. Contacting Community Health Options' ("Health Options") Member Services

Health Options' Member Services Associates are available to assist Members in the resolution of complaints. If you have a complaint about a claim denial, we recommend that you contact a Member Services Associate before filing an Appeal. Sometimes, a claim denial is caused by a minor error or problem that can be resolved by a Member Services Associate without having to go through the Appeal process. You may file an Appeal at any time.

You may make a complaint by calling Member Services at 1-855-624-6463 (TTY/TDD: 711). You can also make a written complaint by mailing or faxing it to:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Fax: 207-402-3745

After we receive your complaint, a Member Services Associate will look into it and respond. If you disagree with our response, you may be able to file an Appeal of the decision. Please contact Member Services if you have questions.

B. Health Options' Internal Appeal Process

Health Options will provide you with an Appeal process that is a full and fair review. Health Options will ensure the following:

a) The person(s) reviewing your Appeal will not be the same persons making the initial Claim Denial, and will not be subordinate to or supervised by the person making the initial Claim Denial;
b) If your Level I Appeal involves a Medical Necessity determination, at least one person reviewing your Appeal will be an appropriate medical professional with experience or training in the medical specialty involved;
c) You will have 180 days after receiving a Claim Denial to file an Appeal;
d) You will have an opportunity to submit written comments, documents, records, and other information relating to the claim without regard to whether those materials or information were considered in the initial Claim Denial;
e) You will be provided upon request, at no cost, reasonable access to, and copies of, all documents, records, and other information relevant to or considered in making the initial Claim Denial;
f) The Appeal will be a "de novo" proceeding. This means that the reviewers will make the Appeal decision without considering or relying upon the initial Claim Denial; and
g) If the Appeal involves a Claim Denial based in some manner on medical judgment:
    i. The Level I Appeal will be conducted by or in consultation with a medical professional with experience or training in the relevant medical specialty;
    ii. The Appeal decision will include the title and qualifying credentials of the person conducting the review; and
    iii. You will be provided with the identity and qualifications of any medical or vocational expert whose advice was considered, whether or not it was used in making the initial Claim Denial.

Your Appeal rights include:

a) Being allowed to review the claim file and to present evidence and testimony as part of the Appeals process;
b) Being given, free of charge, any new or additional evidence considered, relied upon, or generated by Health Options (or at the direction of Health Options) in connection with the claim, unless the evidence is confidential or privileged. Health Options will give you the evidence as soon as possible and with enough time in advance of the decision to give you a reasonable opportunity to respond;
c) Before Health Options can issue a final adverse determination based on a new or additional reason, being provided with the reason, free of charge, with enough time in advance of the decision to give you a reasonable opportunity to respond; and
d) Receiving a notice from Health Options describing your Appeal rights within three business days after Health Options receives your Appeal.

The remainder of this section describes Health Options' internal Appeal process. If you receive an Adverse Benefit Determination, Adverse Health Care Treatment Decision, or Adverse Benefit Determination not involving a Health Care Treatment Decision, you may file an Appeal. Your Appeal will be decided by one or more persons not involved in making the decision that you are Appealing. You may have a Designee or your Provider assist you with your Appeal. Please follow the steps described below.

Members who are visually and/or hearing impaired may request complaint and Appeal process materials in an appropriately accessible format by contacting Health Options Member Services at 1-855-624-6463 (TTY/TDD: 711). If you have special culture needs or require translation services, please contact Member Services at 1-855-624-6463.

1. Beginning Your Appeal

   If you wish to Appeal an Adverse Benefit Determination, Adverse Health Care Treatment Decision, or Adverse Benefit Determination not involving a Health Care Treatment Decision, you must submit your Appeal to Health Options within 180 days from the date of the decision you wish to Appeal. If you do not submit an Appeal within this time limit, you will lose your right to Appeal the decision unless the delay is reasonable under the circumstances and does not negatively prejudice Health Options' rights.

   You will need to give us specific information about your Appeal, including:

   a. Which decision(s) you are Appealing;
   b. Why you disagree with the decision(s); and
   c. What you would like the outcome to be.

   Please provide as much information as possible, including: your Member ID number, Claim numbers, reference numbers, dates of service, Provider names, and any other information that will help us identify the Claims or Services you wish to Appeal. We may need to review your medical records, billing statements, and other documents to decide your Appeal. If we need more information (such as medical records, bills, or other documents) to process your Appeal, your Appeals Coordinator will let you know.

   Please send your Appeal to:

   Community Health Options
   Attn: Appeals Coordinator
   Mail Stop 100
   P.O. Box 1121
   Lewiston, ME 04243
   Telephone: 1-855-624-6463 (TTY/TDD: 711)
   Fax: 207-402-3745

   After we receive your Appeal, an Appeals Coordinator will manage your Appeal throughout the entire Appeal process. We will send you a letter identifying your Appeals Coordinator within three business days after we receive your Appeal. The letter will describe the Appeal process and your rights in more detail. Please contact your Appeals Coordinator if you have questions.

2. Level I Appeal Process

   The Level I Appeal process involves either "standard review" or "expedited review."

   Your Appeal will be eligible for an expedited review if your Appeal involves services that, if delayed, could seriously jeopardize your health or your ability to regain maximum function. We will grant an expedited review of any Appeal for services concerning (1) an Inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has received Medical Emergency services and has not been discharged from the Hospital where Medical Emergency services were provided. You should work with your Provider to request an expedited Appeal. A verbal request for an expedited Appeal can be made by calling Health Options Medical Management at 1-855-542-0880.

   a. Standard Review (Non-Expedited Appeals) Timing and Notification.

      For standard Appeals, we are able to make decisions in most cases within 20 business days after we receive the Appeal request. If you do not provide all of the information we need to decide the Appeal, we will let you know as soon as possible. This may delay our Appeal decision. If we cannot reasonably meet the 20 business-day time frame, we will let you and your Provider know that we are requesting more time and why we need more time. We will make the decision on your first level Appeal and notify you within 20 business days after receiving all necessary information, unless you voluntarily agree to extend the time frame beyond this.

   b. Expedited Review Timing and Notification. For expedited Appeals, an appropriate clinical reviewer, not involved in the initial adverse determination or a subordinate of any individual involved in the initial adverse determination, will investigate and complete expedited review of first level Appeals within 72 hours after we receive your Appeal. We will make a decision sooner if we can. It is critical that you provide all necessary information so that we can complete the expedited review quickly. If you do not provide all of the information

we need to decide the Appeal, we will let you know within 24 hours after the Appeal is filed. This may delay our Appeal decision. For expedited Appeals involving (1) continued Medical Emergency services to screen or stabilize a Member, (2) Urgent Care services, or (3) continued care under an authorized admission or course of treatment, coverage will be continued without liability to the Member until the Member has been notified of the expedited Appeal decision. We may call you and your Provider to tell you our expedited Appeal decision. We will also send our written decision to you and your Provider within two business days after calling you.

c. Denial of Level I Appeal. If we deny your Level I Appeal, we will give you a written decision, which will include the following:

a) The reason(s) for the decision, including reference to the specific Agreement provision, rule, protocol, guideline, evidence or other documents that we used to make the decision;
b) A statement that you may receive, at no cost to you upon request, reasonable access to, and copies of, all documents, records, provisions, rules, protocols, guidelines, internal rules and/or other criteria used in the Appeal decision or initial denial decision;
c) If the denial was based on Medical Necessity or Experimental treatment or similar exclusion or limit, we will provide an explanation of the scientific or clinical judgment for the denial or you will be told that you may request such explanation at no cost;
d) The title and qualifications of the person who conducted the review;
e) A description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material is necessary;
f) How to obtain a second level review;
g) Notice of your right to contact the Maine Bureau of Insurance by telephone at **1-800-300-5000** (within Maine) or **1-207-624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333; and
h) A statement describing all other dispute resolution options available to you, including any further internal review and options or external review and legal actions. If the Appeal involves an Adverse Determination, a copy of the notice of the right to external review and an explanation of how to request external review will be provided.

3. Level II Appeal Process (Voluntary)

If you disagree with the decision of the Level I Appeal process, you may request a second level Appeal. Your Level II Appeal will be reviewed by a Health Options review panel. Health Options shall appoint a panel for each Level II Appeal, which shall include one or more reviewers not involved in the previous adverse determinations. If your Level II Appeal involves a medical determination, the panel will include one or more clinical peers not involved in previous adverse determinations. A second level Appeal decision involving a medical determination adverse to the Member must have the concurrence of a majority of the clinical peers on the panel. You must make a Level II Appeal within 180 days after the date of the Level I Appeal decision. If you do not submit a Level II Appeal within this time, you will lose your right to a Level II Appeal unless the delay is reasonable under the circumstances and does not negatively prejudice Health Options' rights.

You may waive your right to the Level II Appeal process and request an independent external review as provided below.

You have a right to attend the meeting to present your case to the review panel. You or your Designee must tell your Appeals Coordinator if you wish to attend. You may also participate in the meeting by telephone or video conferencing if you wish – please let your Appeals Coordinator know.

You may submit supporting materials both before and at the review meeting and you may ask questions of Health Options representatives. You also may bring someone with you or be represented by someone, including a lawyer, at the review meeting. You also have the right to obtain free of charge from Health Options your medical case and information relevant to your Appeal that is not confidential or privileged.

If you request to participate in the review panel, we will hold a review meeting within 45 days after we receive your request for a Level II Appeal. You will be notified in writing at least 15 days in advance of the review meeting. We will let you know if Health Options will have a lawyer presenting Health Options' case. If you need to postpone the review meeting, please let your Appeals Coordinator know. The decision of the review panel will be sent to you in writing within five business days after a review meeting.

If you do not request to participate in the review panel, you will be provided with a written response to your Level II Appeal within 30 calendar days after we receive your request for a Level II Appeal.

If we deny your Level II Appeal, we will give you a written decision, which will include:

a) The reason(s) for the decision, including reference to the specific Agreement provision, rule, protocol, guideline, evidence or other documents that we used to make the decision;
b) A statement that you may receive, at no cost to you upon request, reasonable access to, and copies of, all documents, records, provisions, rules, protocols, guidelines, internal rules and/or other criteria used in the Appeal decision or initial denial decision;
c) If the denial was based on Medical Necessity or Experimental treatment or similar exclusion or limit, we will provide an explanation of the scientific or clinical judgment for the denial or you will be told that you may request such explanation at no cost;
d) The title and qualifications of the person(s) who conducted the review;
e) Notice of your right to contact the Maine Bureau of Insurance by telephone at **1-800-300-5000** (within Maine) or **1-207-624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333; and
f) A statement describing all other dispute resolution options available to you, including external review.

4. Independent External Review

Appeal decisions involving an Adverse Utilization Determination or an Adverse Health Care Treatment Decision by Health Options are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. Adverse Utilization Determinations for purposes of independent external review include Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered Benefit, Experimental or Investigational treatment or services, and rescission.

The external review decision must be made within 30 days after the independent review organization receives the request for the review. However, the decision must be made within 72 hours if delay would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.

If the independent review organization decides in your favor, the decision is binding on Health Options.

Normally, you must first complete Health Options' first and second level Appeals process to be eligible for independent external review. However, you are not required to complete the first and second level Appeals process if:

a. Health Options has failed to make a decision on your first or second level Appeal in the time frames noted above;
b. Health Options has not followed all the federal and state requirements applicable to Health Options' internal Appeal process;
c. You have applied for expedited external review at the same time as applying for an expedited internal Appeal;
d. You and Health Options mutually agree to bypass the Health Options Appeals process, or with respect to a second level Appeal you waive your right to a second level Appeal;
e. Your life or health is in serious jeopardy;
f. The Member for whom external review is requested has died; or
g. The Adverse Utilization Determination or Adverse Health Care Treatment Decision concerns an admission, availability of care, a continued stay, or health care services when the Member has received Medical Emergency services but has not been discharged from the facility that provided the Medical Emergency services.

You may obtain review under this section even though you have failed to obtain Prior Approval prior to receiving a Covered Service.

You must request external review by making your request in writing to the Maine Bureau of Insurance at 34 State House Station, Augusta, ME 04333. You must also make your request within 12 months after Health Options' final denial of Benefits under our internal Appeals process. You will not be charged a fee to initiate external review. You may have someone else make this written request for you if this person:

a. Has your written consent to make the request;
b. Is authorized by law to make the request on your behalf; or
c. Is your family member or treating Provider, but only if you are unable to make the request.

5. Second Opinions.

In any Appeal in which a professional medical opinion regarding a health condition is a material issue in the dispute, you may be entitled to an independent second opinion from a Provider of the same specialty, paid for by the Plan.

C. Complaints

If you have any complaints about Health Options' services or your Plan, please contact Member Services:

Community Health Options
Attn: Member Services Department
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Telephone: 1-855-624-6463 (TTY/TDD: 711)
Fax: 207-402-3745

Health Options will respond to you as quickly as we can. Most complaints can be investigated and responded to within 30 days.

You may also submit complaints to the Maine Bureau of Insurance:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1-800-300-5000 (within Maine) or 1-207-624-8475 (outside Maine)

D. Legal Action against Health Options

A Member may only bring legal action against Health Options for an Adverse Utilization Determination or Adverse Health Care Treatment Decision if the Member or the Member's representative has exhausted the complaint and Appeals process outlined in section 8. A Member must bring this type of legal action within three years from the earlier of: (1) the date of issuance of the written external review decision, or (2) the date of issuance of the underlying Appeal decision.

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three years after the time in which written proof of loss is required to be furnished.

9. RENEWABILITY AND TERMINATION

This Agreement and your coverage will be in effect until terminated as provided by this Agreement, as applicable, and by the Federally Facilitated Marketplace (the Marketplace) requirements, as applicable. Once your Agreement terminates, the Plan will not provide Benefits for Covered Services rendered after the date of termination. If your Plan is terminated by Community Health Options ("Health Options"), we will notify you of the date of your coverage termination.

A. Renewability

This Agreement will renew as required under state and federal law. The Agreement will be renewed when the Premium is paid in full by the end of the applicable grace period. Health Options may not renew this Agreement for: (a) nonpayment of Premiums, (b) fraud or intentional misrepresentation of material fact, (c) termination of Plan as allowed under state and federal law, (d) failure of the Subscriber to reside in the service area of the Plan, or (e) discontinuance of coverage by Health Options in the service area.

B. Termination by Member

A Subscriber may request that we end this Agreement and coverage under the Plan at any time.

For Plans purchased directly from Health Options, send a signed, written statement to Health Options. This Agreement and the Member's coverage will be terminated effective the last day of the month in which Health Options receives written notice or the last day of a future month as requested by the Member.

For Plans purchased through the Marketplace, inform the Marketplace of your request to voluntarily terminate. The Marketplace will determine the termination effective date. Health Options cannot terminate Marketplace plans or change effective dates issued by the Marketplace, without Marketplace Approval.

If the Member receives coverage under the Plan through the Marketplace and the Member becomes eligible for coverage under Medicaid, the Children's Health Insurance Program, or a Basic Health Program, the termination will be effective the day before new coverage starts. Proof of coverage enrollment date is required.

Health Options will refund to the Member Premiums paid for periods after the date of termination.

C. Termination by Health Options

Health Options may terminate this Agreement and coverage under the Plan as follows:

1. Health Options will give 45 days' notice of termination for:

    a. Failure to meet all of the eligibility requirements for coverage under the Plan and imposed by the Marketplace, as applicable;
    b. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. In addition, Health Options may rescind this Agreement and coverage as provided in section 9.D; and
    c. Non-payment of Premium as provided in section 3.D.

2. Health Options will give 90 days' notice of termination of the Plan if:

    a. The Plan is no longer offered in the service area or Health Options ceases offering any coverage in the service area as permitted by state and federal law; or
    b. The Plan is terminated or no longer certified by the Marketplace.

3. If the Member switches coverage, Health Options will give notice of termination as required by Federal law.

Health Options will refund to the Member Premiums paid for periods after the date of termination.

D. Rescission

Health Options reserves the right to rescind a Member's coverage as of the last date of eligibility for any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member. Any claims incurred after the date of eligibility for which Health Options is unable to recover payment from the Provider will be the responsibility of the Subscriber.

E. Notice of Termination

A Member has the right to designate a third party to receive notice of termination of this Agreement, and to change the person designated to receive such notice, by completing and sending to Health Options a Third Party Notice Request form. Please contact Member Services at 1-855-624-6463 (TTY/TDD: 711) to make or change such designation. Health Options will send a Third Party Notice Request form within 10 days of the request.

F. Right to Reinstatement

1. Cognitive impairment or functional incapacity

   Under Maine law, a Member may be eligible to reinstate the Agreement within 90 days after the termination if non-payment of Premium or other lapse or default took place because you suffered from cognitive impairment or functional incapacity at the time of termination. You, someone authorized to act on your behalf, or a Dependent may request reinstatement.

   We may require you to prove that you suffered from cognitive impairment or functional incapacity at the time of termination. This proof may include getting a medical examination at your own expense or giving us medical records. If you qualify for reinstatement under this section, we will reinstate your coverage without a break in coverage. We will reinstate your coverage as though it had not been terminated. Your reinstated coverage will be subject to the same terms, conditions, exclusions, and limitations.

   Before your coverage is reinstated, you must pay the amount due from the date of termination through the month in which we bill you within 15 days after we request that you make payment. If you do not pay in time, we are not required to reinstate your coverage and you will be responsible for claims incurred after the date of termination.

   If we deny your request for reinstatement, we will send a notice to you and to the person who made the request, if different. You have the right to an Appeal under section 8, or to request a hearing before the Maine Bureau of Insurance, within 30 days after you receive the notice from us.

   Notice of cancellation will be provided to you and your designated third party at least 10 calendar days before cancellation of this Agreement. Such notice shall include the reason(s) for cancellation, amount of unpaid Premium and the date by which the Premium must be paid, if applicable, and notice of the right to guaranteed issuance of individual health plans.

2. Acceptance of Premium

   If coverage under this Agreement terminates due to non-payment of Premium, we require an application for reinstatement. We will advise you of the effective date of reinstatement by giving you written notice of the date. In any case, the reinstated coverage provides Benefits only for:

   a. Injury occurring after the effective date of reinstatement; and
   b. A condition first manifesting itself more than 10 days after the effective date of reinstatement.

10. OTHER PROVISIONS

A. Assignment of Benefits

You may assign Benefits provided for Covered Services only to the Provider rendering services. You may not assign this Agreement to anyone else without our written permission.

B. Entire Agreement

This Agreement, the *Schedule of Benefits*, and any *Application* make up the entire agreement between you and Community Health Options ("Health Options") with respect to the subject matter contained in these documents.

C. Changes to this Agreement

This Agreement and the *Schedule of Benefits* may be amended by Health Options upon sixty (60) days' written notice to you. Amendments can only be made in writing by an authorized officer of Health Options. No agent has authority to change this Agreement or waive any of its provisions. No statement made by an applicant for coverage shall void the coverage or reduce Benefits unless such statement is contained in the written application signed by the applicant. All statements contained in any application for coverage are deemed to be representations and not warranties.

Rates are guaranteed for the Calendar Year rating period as approved by the appropriate Federal and State regulators. We will notify you at least 60 days before an increase in Premium.

D. Non-enforcement

If Health Options does not enforce compliance with any provision of this Agreement, this non-enforcement shall not be deemed to be a waiver by Health Options of that provision or any other provision of this Agreement.

E. Relationship between Health Options and Providers

Health Options has separate contracts with Plan Providers. Plan Providers are independent contractors. They are not agents or employees of Health Options. Plan Providers may not modify this Agreement or the *Schedule of Benefits*. Only Health Options may modify this Agreement as provided under section [10.C]. Plan Providers cannot make binding promises on behalf of Health Options.

Health Options may change its arrangements with Plan Providers, including addition and removal of Plan Providers. Health Options will try to give you at least 60 days' notice before Health Options removes a Plan Provider. If it is impossible for Health Options to give you this much notice, Health Options will give you as much notice as possible. Health Options will provide continued access to providers removed from the Plan for 60 days from the date of termination of the contract in the event that the contract is terminated for any reason other than unprofessional behavior.

Health Options does not render health care services, supplies, or equipment to Members. Instead, Health Options arranges Covered Services for Members and pays Benefits in accordance with this Agreement. It is Providers who render health care services, supplies, and equipment to Members. Health Options does not interfere with the independent medical judgment of Providers.

F. Relationship between Health Options and the Marketplace

Health Options and the Marketplace are two separate entities. Statements made by the Marketplace call center representatives do not represent Health Options and cannot be relied upon for binding promises on behalf of Health Options. Health Options is not responsible for incorrect or misleading information given by a call center representative of the Marketplace.

G. Notice

Any notice to a Member will be sent to the last address of the Member on file with Health Options. Notices to Health Options should be sent to:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243

H. Disasters

In the event of a war, riot, epidemic, or other major disaster (natural or manmade) (together, "Disasters"), Health Options will try to arrange for services. Health Options is not responsible for the costs or outcome of its inability to arrange for services due to a Disaster.

Premiums will be refunded if coverage is not provided.

I. Confidentiality of Member Information

Health Options is committed to ensuring and safeguarding the confidentiality of its Members' personal and medical information. We are subject to various federal and state laws regarding how we access, use, and disclose Member information. We will access, use, and disclose the minimum information necessary to accomplish the purpose of the task. We will only access, use, and disclose your information as allowed by law or obtain your specific permission to access, use, or disclose your information. We will not share your personal information or protected health information with any plan sponsor (such as employers), as applicable, without a signed disclosure authorization form from you.

Examples of when we will need to access, use, and disclose Member information include:

1. Obtaining and sharing information with your Providers so we can perform Prior Approval activities;
2. Conducting quality activities;
3. Obtaining information from Providers so we can properly pay Benefits; and
4. When we are required or authorized by law to access, use, or disclose information.

Health Options sometimes contracts with other persons and entities to perform tasks on behalf of Health Options. Health Options requires these other persons and entities to comply with Health Options' policies on protecting Member information and applicable state and federal laws.

There may be times when Health Options needs your (or your Designee's) written authorization to disclose your information. This may be true even if you request that we disclose your information. In cases where we need written authorization, we will provide a copy of our written authorization form to you (or your Designee) to complete and sign.

We will protect your Protected Health Information as required by the Health Information Portability and Accountability Act (HIPAA). For more details on how we will handle your Protected Health Information, please see our Notice of Privacy Practices at https://www.healthoptions.org/privacy-policy.

J. Providing Health Options with Information

The Member agrees that Health Options may have access to (1) all health records and medical data from Providers rendering care to Members, and (2) information about other types of insurance, such as auto insurance, Health Plans, and homeowners' insurance, and other sources of payment. Sometimes, your Providers or other insurers may need your (or your Designee's) written authorization to disclose information to us. Please ask your Providers or other insurers about how to do this.

K. Time Limit on Certain Defenses

After 3 years from the date of the Agreement, no misstatements, except fraudulent misstatements, made by the Member in the *Application* for this Agreement shall be used to void the Agreement or to deny a claim.

L. Physical Examination; Autopsy

We have the right and opportunity, at our own expense, to examine the Member when and as often as it may be reasonably required during the pendency of a claim hereunder and to make an autopsy in the case of death, unless forbidden by law.

M. Conformity with State Statutes

Any provision of this Agreement that, on its effective date, is in conflict with the statutes of the State of Maine, is hereby amended to conform to the minimum requirements of such statutes.

N. Subcontractors

Health Options may subcontract with individuals and entities to provide services on behalf of Health Options. Subcontractors may include, but are not limited to, prescription drug benefit managers and behavioral health managers. Subcontracted duties may include Benefit determinations, paying claims, administrative services, or other duties.

O. Genetic Information

Health Options will not discriminate on the basis of genetic information as provided in the federal Genetic Information Nondiscrimination Act of 2008.

11. GLOSSARY

Accidental Injury. Accidental bodily injury sustained by a Member that is the direct cause of the condition for which Benefits are provided and that occurs while this Agreement is in force.

Advance Payments of Premium Tax Credit or Tax Credit. The federal tax credit available to eligible persons who apply for private insurance coverage through the Federally Facilitated Marketplace to help offset the costs of monthly Premiums.

Adverse Benefit Determination. An Adverse Benefit Determination is a determination, including a Claim denial, by or on behalf of Community Health Options ("Health Options"), any (1) Adverse Health Care Treatment Decision, or (2) denial reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including an action based on a determination of a Member's ineligibility to participate in the Plan.

Adverse Health Care Treatment Decision. A health care treatment decision made by or on behalf of Health Options denying in whole or in part payment for or provision of otherwise Covered Services requested by or on behalf of a Member. Adverse Health Care Treatment Decisions include rescission determinations and initial coverage eligibility determinations as provided under federal law.

Adverse Utilization Determination. A determination by Health Options that: (1) an admission, availability of care, continued stay, or other health care service has been reviewed and does not meet Health Options' requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; and (2) payment for the requested services is therefore denied, reduced without further opportunity for additional service, or terminated.

Agreement. The legal document that defines the relationships between Members and Health Options. It describes the Benefits, limitations, conditions and exclusions, and contains other important information relevant to Members enrolled in the Plan.

Ambulatory Surgery Center. A facility that is licensed by a state or certified by Medicare as an ambulatory surgery center.

Amendment. An addition, deletion, or revision to the terms and conditions of this Agreement.

Appeal. A request by a Member or the Member's Designee to have Health Options review a decision as described in section 8 of this Agreement.

Appeals Coordinator. The individual who manages a Member's Appeal throughout the entire appeal process.

Application. Health Options or the Marketplace application submitted for the purpose of securing health insurance from Health Options.

Applied Behavior Analysis. The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Balance Billing. When a Provider bills a Member for some or all of the remaining charges not paid by the Plan (this does not include Member Out-of-Pocket Costs).

Basic Health Program. A program under the Patient Protection and Affordable Care Act that allows states to offer subsidized coverage for certain individuals with low incomes. Not all states offer a Basic Health Program.

Benefits. Payments we make on your behalf under this Agreement and your coverage under the Plan.

Binding Premium Payment. The full premium payment due in order to effectuate the Plan. This premium is due on or prior to the effective date of coverage. No grace periods apply.

Board of Directors. The Board of Directors governs Health Options as a private, nonprofit Consumer Operated and Oriented Plan ("CO-OP").

Calendar Year. When your coverage first begins under the Plan, the Calendar Year is the effective date of your coverage through the earlier of (1) December 31 in the year your coverage first begins, or (2) the date your coverage ends due to termination as defined in section 9. For years after the year in which your coverage first begins under the Plan, the Calendar Year is January 1 through the earlier of (1) the first occurring December 31, or (2) the date your coverage under the Plan ends.

Children's Health Insurance Program ("CHIP"). CHIP is a federal and state program that provides low-cost health insurance coverage for children in families who earn too much income to qualify for Medicaid coverage but can't afford to purchase private health insurance.

Chiropractor or Doctor of Chiropractic. A person who is licensed to perform chiropractic services.

Claim. A request for payment under the Plan. The requirements for Claim submission are described in Section 6.

Clean Claim. A claim that does not contain a defect requiring investigation or development prior to adjudication. Clean claims must be filed within the timely filing period. For Plan Providers, the timely filing period is listed within the Provider's contract with Health Options.

COBRA. The federal law known as the Consolidated Omnibus Budget Reconciliation Act.

Coinsurance. The percentage paid by a Member toward the cost of the Maximum Allowable Amount of some Covered Services.

Community Mental Health Center. An institution that is licensed as a comprehensive community mental health center.

Copayment. Fees payable by Members for certain Covered Services. Copayments are payable at the time of the visit or when billed by the Provider.

Cosmetic Services. Medical and surgical services intended solely for the purpose of changing or improving appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Services. Services, supplies, or treatment covered by this Agreement and as described in section 4.B. Cost-sharing applies to Covered Services, as described in your *Schedule of Benefits*. Determination of Claim payment is described in Section 6.

Custodial Care. Services that are (1) not for the primary purpose of treating an illness or injury or primarily intended to help a patient gain materially improved functioning within a reasonable timeframe established in a plan of care, and (2) for the purpose of assisting with activities of daily living. Such services include, but are not limited to, help with: personal hygiene, bathing, dressing, skin and nail care, toileting, preparing meals and feeding, walking or transferring positions, giving medicines that are typically self-administered, and catheter care. Services may be Custodial Care regardless of whether such services are performed or ordered by a Provider and regardless of where the services are performed.

Day Treatment Program. Mental health or substance abuse services on an individual or group basis for more than two hours, but less than 24 hours a day, in a Hospital, mental health center, Substance Abuse Treatment Facility, or Community Mental Health Center.

Deductible. If your Plan has a Deductible requirement, the Deductible is the amount you are required to pay for Covered Services each Calendar Year before the Plan begins to pay Benefits.

Dental Service. Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

Dependent. A member of the Subscriber's family who meets the eligibility requirements to be a Dependent under this Agreement.

Designee. Someone who is 18 years of age or older whom you designate to act on your behalf.

Diagnostic Service. A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Disease Management. A program offered to all Community Health Option Members with the goal to empower Members to effective self-manage their chronic conditions. Health Options will provide additional support to Members and Providers when needed.

Domiciliary Care. Services (including therapeutic services) and room and board provided in a hotel, health resort, home for the aged, residential facility, treatment center, halfway house, or educational institution because a Member's own living arrangements are inadequate or unavailable.

Durable Medical Equipment. Equipment that meets all of the following criteria:

1. Can withstand repeated use;
2. Is used only to serve a medical purpose;
3. Is appropriate for use in the patient's home;
4. Is not useful in the absence of illness, injury or disease; and
5. Is prescribed by a Physician.

Durable Medical Equipment does not include fixtures installed in your home or installed on your property.

Early Intervention Services. Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Emergency Services. Those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the enrollee's physical and/or mental health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Experimental or Investigational. Procedures, treatments, services, equipment, supplies, devices, drugs, medications, and biologics that Health Options determines to be experimental or investigational for the purposes of diagnosis or treatment of an illness or injury. Health Options makes these determinations based upon criteria adopted by Health Options and as required by federal law. The following are examples of Experimental or Investigational items:

1. Drugs classified by the FDA as treatment investigational new drugs;
2. Services involved in clinical trials;
3. Devices that have an FDA investigational device exemption; and
4. Devices for which the FDA has limited access or approval.

Federally Facilitated Marketplace. A mechanism intended to provide a transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans.

Federally Qualified Health Center. A facility that is designated as a federally qualified health center by the U.S. Department of Health and Human Services under the United States Public Health Service Act.

Freestanding Imaging Center. An institution that is licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center.

Health Plan. An individual or group plan that provides, or pays the cost of, medical care.

Hearing Aid. A non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including but not limited to frequency modulation systems.

Home Health Agency. An institution that is licensed as a home health agency.

Hospice. An organization that is licensed to deliver Hospice Care.

Hospice Care. A holistic model of care for the terminally ill which is focused on comfort, rather than curative treatments. The Hospice care team is aimed at developing and implementing a plan of care with the Member and their family system, prioritizing pain management and symptom control. The majority of terminally ill persons receive hospice care in their home. Hospice care teams are on call 24/7 to address the needs of the Member. The hospice care team and services may include a physician, nurse, care manager, home health aide, social worker, spiritual care, physical therapy, occupational therapy, speech therapy, volunteers, durable medical equipment, medical supplies, medications, and bereavement.

Hospital. An institution that is duly licensed by a state as an acute care, rehabilitation, or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Errors of Metabolism. A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Infertility. Infertility means either of the following:

1. Being unable to conceive despite engaging in frequent sexual relations without contraception for a year or more; or

2. Having a condition that is a cause of infertility recognized by the American Congress of Obstetricians and Gynecologists , the American Urological Association, or another appropriate independent medical society.

In-Home Biometric Monitoring. The delivery of in-home monitoring devices that allows Providers to remotely monitor patients in their homes and enables secure, two-way flow of information between remote Providers and patients.

In-Network. A Provider is considered In-Network if the Provider is contracted as a Plan Provider. Visits or services with Plan Providers are Covered as In-Network.

Inpatient. A Member admitted to a Hospital, Skilled Nursing Facility, or residential treatment facility for an overnight stay in a bed. "Inpatient" excludes a patient who is kept overnight in a Hospital solely for observation, regardless of whether the patient occupies a bed.

Inpatient Stay. A period of uninterrupted Inpatient confinement that begins with formal admission and ends upon discharge. An Inpatient Stay may include a Medically Necessary transfer from one Hospital to another Hospital as an Inpatient.

Maintenance Medications. A prescription drug that is prescribed to you by your Provider for treatment of a long-term condition or illness (e.g., blood pressure medication, cholesterol medication). Medications that are prescribed to treat short-term conditions (e.g., antibiotics) are not considered Maintenance Medications.

Maintenance Therapy. Any service, procedure, treatment, or therapy that has the primary purpose of preserving the present level of function and prevents deterioration of that function, as opposed to improving a function (within a reasonable timeframe established in a plan of care) to an extent that may allow for a more independent existence. Maintenance Therapy occurs when the condition of the patient receiving the service, procedure, treatment, or therapy does not or is not expected to materially improve within a reasonable timeframe established in a plan of care, or when the goals of a treatment plan have been met.

Marketplace. In Maine, the Federally Facilitated Marketplace.

Maximum Allowable Amount or Maximum Allowance. The maximum amount that a Member and Health Options will pay a Plan Provider for a Covered Service. The Maximum Allowable Amount or Maximum Allowance equals the Usual, Customary, and Reasonable Charge for a Covered Service.

Medicaid. A state medical assistance program under Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medical Emergency (Emergency Medical Condition). A medical condition, physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health, physical or mental, of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. For pregnant women, having contractions and there is inadequate time for a transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or unborn child.

Medical Necessity or Medically Necessary. Health care services or products provided to a Member for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1. Consistent with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site, and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of best practices in the medical profession; and
5. Not primarily for the convenience of the Member or Provider.

Medicare. The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member. Any person, including Dependents, covered by this Agreement.

Member Representative (or Authorized Representative). A person who has been given written legal authority to represent the Member. The treating physician, healthcare Provider or Organization acting on behalf of the Member is recognized as a Member's Representative. Sometimes referred to as a Member's Designee.

Morbid Obesity. A condition of persistent and uncontrolled weight gain that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Non-Plan Providers. Health care Providers that do not have a written agreement with Health Options to provide health care services under this Agreement. Providers who have not contracted or affiliated with our specified subcontractor(s) for the services they perform under this plan are also considered Non-Plan Providers.

Open Enrollment. The timeframes described in section 3 where individuals may first enroll for coverage under the Plan. These are also the timeframes when current Members may change plans offered by Health Options.

Orthognathic Surgery. A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device. A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Out-of-Pocket Cost. The portion of the cost of services for which the Member is personally responsible. Out-of-Pocket Costs include Copayments, Coinsurance, and Deductibles.

Outpatient. A patient, not an Inpatient or Day Treatment Program participant, who obtains services at a facility of a Provider. Outpatient includes an overnight observation in a Hospital, even if the patient uses a bed.

Physician. A licensed medical doctor (MD) or doctor of osteopathic medicine (DO).

Placed for Adoption or Placement for Adoption. The assumption and retention of a legal obligation for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered Placed for Adoption.

Plan. The health insurance plan to which the Agreement applies.

Plan Provider. Licensed or certified Providers who are under contract with Health Options to provide care to the Plan Members. Plan Providers are listed in the Provider Directory.

Premium. The periodic fee required for coverage of Members as provided in this Agreement.

Prescription Drugs. A pharmaceutical drug that legally requires a medical prescription to be dispensed.

Primary Care Provider ("PCP"). A Physician specialist in internal medicine, family practice, general practice, pediatrics, or obstetrics and gynecology, or an advanced practice registered nurse or certified midwife licensed by the applicable state nursing board, who is under contract with Health Options to provide and authorize Members' care.

Prior Approval. The system by which a Plan Provider or, when obtaining services Out-of-Network, Member must first have obtained approval from Health Options before receiving Covered Services. See Section 2 for more information.

Provider. A licensed health care institution, facility, or agency or an independently billing, licensed, or certified health care professional acting within the scope of his or her license or certification. Providers also include (i) health care institutions, facilities, agencies, and professionals that have written participating agreements with us (Plan Providers), and (ii) other health care institutions, facilities, agencies, and professionals as required by law.

Provider Directory. A list of Plan Providers, including PCPs and Specialists. The Provider Directory may be updated without prior notice.

Radiation Therapy. The use of high energy penetrating rays to treat an illness or disease.

Referral. The recommendation of a Provider (usually the PCP) for a Member to receive Covered Services from another Provider.

Rural Health Clinic. An institution that is certified by the U.S. Department of Health and Human Services under the United States Rural Health Clinic Services Act.

Service Area. The Plan's Service Area is the states in which the Plan is offered. We contract with Plan Providers in and around the Service Area to provide coverage for our Members.

Skilled Nursing Facility (SNF). An institution that meets all of the following requirements:

1. Be operated pursuant to law;
2. Approved for payment of Medicare benefits, or otherwise qualified to receive approval for payment of Medicare benefits;
3. Primarily engaged in providing, in addition to room and board, skilled nursing care under the supervision of a duly licensed Physician;
4. Provides continuous 24-hours-a-day nursing service by or under the supervision of a registered nurse; and
5. Maintains a daily record for each patient.

Special Enrollment. Enrollment of a Member or Dependent under the Plan as allowed under section 3. Special Enrollment is allowed after certain events happen.

Specialist. A Provider who practices in a specialty area of medicine, including, but not limited to, radiology, cardiology, surgery, orthopedics, and oncology.

Stabilized. With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.

Subscriber. The person who meets the eligibility requirements to be a Member as described in this Agreement and who is not a Dependent. For a person to qualify as a Subscriber, we must have received and approved the required *Application* and Premium.

Substance Abuse Treatment Facility. A residential or nonresidential institution that meets all of the following requirements:

1. Licensed or certified as a Substance Abuse Treatment Facility;
2. Provides care to one or more patients for alcoholism and/or drug dependency; and
3. Is a freestanding unit or a designated unit of another licensed health care facility.

Urgent Care. Medical care or treatment with respect to which the application of the time periods for making non-urgent Prior Approval decisions could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or, in the opinion of an attending Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This does not include Medical Emergency services. Urgent Care does not include medical care or treatment with respect to a Medical Emergency.

Usual, Customary, and Reasonable Charge. As determined by Health Options, an amount that is consistent with a usual range of charges by Providers for the same, or similar, services, equipment, or supplies in the geographic area where the service, equipment, or supply was provided to a Member.

Utilization Review. The process Health Options uses to determine the Medical Necessity, appropriateness, effectiveness, or efficiency of health care services. Techniques include Inpatient admission review, continued Inpatient Stay review, discharge planning, post-admission review, and case management.