# Member Benefit Agreement

**Traditional Group Plans Including: Community Accord, Community Advantage, Community Assure, Community Flex, Community Merit, Community Option, Community Preferred, Community Prime, and Community Select.**

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 this Agreement terminates as provided in this Agreement, when the Coverage Group pays the Premium charges, your coverage renews for the period covered by the Premium.

**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

Non-English speaking Members may also call Health Options Member Services at 1-855-624-6463. Health Options offers free language interpretation services for people who do not speak English or who have limited English-speaking abilities.

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.

**THIS POLICY IS ALSO AVAILABLE AS A CHILD ONLY POLICY**

**Plan Effective On or After Date: 1/1/2019**

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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 provided or arranged through Health Options' network of Primary Care Providers (PCP), Specialist Providers, and other Providers. The Plan provides Benefits for the health care services described in this Agreement and in the Schedule of Benefits.

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.

<u>Our Mission:</u>

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

<u>Our Values:</u>

*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.*

<u>Our Vision:</u>

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

## C. How this Agreement Works

1. <u>Generally</u>

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, that is, costs you must pay, are detailed in the *Schedule of Benefits.*

2. <u>Defined Words</u>

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. Network Providers and the Provider Directory

The Provider Directory lists the Primary Care Providers (PCPs), Specialists, Hospitals, and other Network 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 Network Providers, including contact information and office hours. Visit https://www.healthoptions.org/Search-provider to view the regularly updated Provider Directory. If you do not have online access, you may obtain a printed copy by calling Member Services. Members are encouraged to use Network Providers. Your Out-of-Pocket Costs are typically lower when you receive Covered Services from a Network Provider rather than a Non-Network Provider. Section 6 describes how using a Non-Network Provider can affect your Out-of-Pocket Costs. Health Options' Member Services Associates can answer questions about our Network Providers at 1-855-624-6463.

Network Providers have contracts with Health Options that can be terminated from time to time, even without notice. If your Network 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 Network 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 Network Provider with the same Out-of-Pocket Costs to allow for a smooth transition to a new Network Provider. If you are undergoing a course of treatment with a Network Provider who leaves Health Options' network, you may have the same Out-of-Pocket Costs with that Network Provider for at least 90 days from when we notify you that your Network Provider is leaving. If you are a pregnant Member in the 2nd or 3rd trimester and we notify you that your Network Provider is leaving, you may have the same Out-of-Pocket Costs, related to that pregnancy, with that Network Provider through postpartum care.

In the event that you are not able to obtain services from a Network 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 Network Provider.

5. Service Area

Health Options' Service Area consists of Maine. We also contract with Network Providers in New Hampshire and a limited number of Network Providers in Vermont and Massachusetts. A Travel Network for coverage outside of the Service Area is included under this plan. Providers not directly contracted with us or not included in the Travel Network are considered Non-Network Providers. Non-Network Providers within the Service Area and outside the Service area are considered Out-of-Network. **Services received from Non-Network 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.*
- *Information about your Out-of-Pocket Costs, and an explanation of your financial responsibility for services provided to you.*
- *Be treated in a manner that respects your privacy and dignity. We will follow applicable laws and our policies when we handle your information.*
- *Participate with your Providers in making decisions about your health care.*
- *Voice complaints or file Appeals with the Plan, and to contact regulatory bodies about the Plan.*
- *Make recommendations regarding the Plan's Member Rights and Responsibilities policies.*

- *Receive appropriate assistance from Health Options in a prompt, courteous, and responsible manner.*
- *Be promptly informed of termination or changes in Benefits, services, or Network Providers.*
- *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; and the right to contact the Insurance Department listed on the cover of this Agreement.*
- *Adequate access to Providers near your home or work within the Plan's Service Area.*
- *Receive detailed information about which services require Prior Approval and how to request Prior Approval.*
- *Have access to a current list of Network Providers in the Plan's network.*
- *A candid discussion of appropriate or medically necessary treatment options for your conditions regardless of cost or benefit coverage.*
- *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 (that you must do):*

*You have a responsibility to:*

- *Provide honest and complete information to the Plan and to your Providers.*
- *Notify the Plan of any errors or omissions in your account upon discovery in a timely manner.*
- *Choose a Network Primary Care Provider (PCP) for yourself and any Dependents.*
- *Present your Member identification card before you receive care or, in emergency situations, after you receive care.*
- *Pay your applicable Deductible, Coinsurance and Copayment amounts.*
- *Inform the Plan of any changes in family size, address, phone number, or Member eligibility status in a timely manner.*
- *Make Premium payments on time and to understand the premium payment grace periods, even if you have made arrangements with a third party to make such payments.*
- *Notify the Plan if you have any other insurance coverage.*

*As a Member of the Plan, we strongly suggest that you also:*

- *Read and understand the information that you receive about your Plan.*
- *Know how to properly access coverage and utilize your Plan.*
- *Understand your health problems and participate in developing treatment goals that you agree to with your Providers.*
- *See your Primary Care Provider or an appropriate Specialist at least once per year, if you have a chronic medical condition, so s/he can evaluate your condition and provide updates to your treatment plan as needed.*
- *Express your opinions, concerns or complaints in a constructive way to the Plan or to your Provider.*
- *Follow plans and instructions for care that you have agreed to with your Provider.*
- *Transition to Medicare or Medicaid plans when you are eligible for coverage under these plans.*

## 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 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 clinical specialists and clinical navigators work closely with your Primary Care Provider and local care management teams to coordinate your care. Our clinical specialists and clinical 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. The Medical Management team is available to receive after hours communication.

1. Chronic Condition Support (Disease Management)

   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 Medical 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 in to our Disease Management program at any time by contacting Member Services at 1-855-624-6463 or by telling the Community Health Options® clinical specialist/navigator who is calling you. You can always change your mind and opt back in by calling Member Services at 1-855-624-6463.

2. Healthy Options: Support of Healthy Living

   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 clinical specialists and clinical navigators 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

   When you are admitted to a Non-Plan facility, you or your representative have a responsibility to notify Health Options of your admission within 24 hours.

   Should you be admitted to a Hospital that is a Non-Network 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 Network 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 Network Provider. You may be responsible for charges above the Maximum Allowable Amount (also known as balance billing). When there is an inadequate network, balance billing does not apply.

   We will review your situation to determine if continued coverage by a Non-Network Provider at an In-Network rate is reasonable or if transfer to a Network Provider is required. If we determine transfer to a Network Provider is required and you decide to stay at the Non-Network Provider, the rest of your Inpatient Stay Out-of-Pocket Costs will be at the Non-Network Provider (or Out-of-Network) cost-sharing level. If we determine, due to cost or medical condition, you should not be transported to a Network 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 Network 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. <u>While You Are in the Hospital</u>

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.

<u>End of Benefits</u>

When we decide that the Plan will no longer cover your Inpatient Stay at the Network Provider 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. <u>Observation Status</u>

If you have not been admitted to a Hospital but are registered 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. Observation status is limited to 48 hours or less. If you are still in observation status at 48 hours, you must meet medical criteria for admission or be discharged to a lower level of care.

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

1. <u>Choosing Your PCP</u>

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 an In-Network 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 Network 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.

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 Network Provider. Please see the Preventive Services (section 2.H) for more information.**

2. <u>Obtaining Care from Your PCP</u>

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.

3. Federally-Required Patient Protection Disclosure

Community Health Options® generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, Health Options may designate one for you. For information on how to select a primary care provider, contact Health Options at 855-624-6463.

You do not need prior approval from Health Options or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior approval for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit HealthOptions.org/Search-Provider or contact Member Services at 855-624-6463.

**D. Going to the Hospital or a Specialist**

This Plan covers Hospital, Behavioral Health and Specialist services. The Plan does not require Referrals, 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.

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 Network Provider facility, the staff at that facility is required to notify Health Options of your admission. If you are admitted to a Non-Network 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-Network 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 Network Provider (or In-Network) cost-sharing level. You may be responsible for charges above the Maximum Allowable Amount (also known as balance billing). When there is an inadequate network, balance billing does not apply. Refer to Section 2.B for information regarding Hospital admissions.

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 but is not a medical emergency.

**E. Telemedicine Policy**

This plan provides coverage for Telemedicine. 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. As a condition of benefit coverage an interactive audio and video telecommunications system that permits real-time communication between the distant and originating site must be employed. Telemedicine does not include the use of audio-only telephone, facsimile machine, texting or e-mail. Standard benefit requirements are applicable to Telemedicine.

**F. Therapeutic, Adjustive and Manipulative Services Provided by Specialists**

A Member may obtain Medically Necessary therapeutic, adjustive or manipulative services from a Doctor of Chiropractor Medicine or doctor of osteopathic medicine, who is a Specialist in the provision of therapeutic, adjustive of manipulative services, for 3 weeks or a maximum of 12 visits by submitting a complete report to Health Options within 10 working days after the first consultation with the Member. Health Options will not provide Benefits for therapeutic, adjustive or manipulative services and the Member will not be liable for any unpaid fees if the report is not submitted. Health Options will confirm receipt of the report and notify the Member and Doctor of Chiropractor Medicine or doctor of osteopathic medicine.

The report by the treating Doctor of Chiropractor Medicine or doctor of osteopathic medicine shall contain:

- The Member's complaint including the nature of the accidental bodily injury or sudden, sever pain or the chronic condition;
- Related history
- Examination
- Initial diagnosis
- Number of visits completed to date in the calendar year; and,
- Treatment plan.

If the Member and Doctor of Chiropractor Medicine or doctor of osteopathic medicine determine that the condition of the Member has not improved after 3 weeks of treatment or a maximum of 12 visits the therapeutic, adjustive and manipulative treatment will be discontinued.

If the Doctor of Chiropractor Medicine or doctor of osteopathic medicine recommends treatment beyond 3 weeks or a maximum of 12 visits, the Doctor of Chiropractor Medicine or doctor of osteopathic medicine shall send a report to the Health Options within 10 working days of the commencement of the extended treatment which includes Member progress and outlining a treatment plan for extended therapeutic, adjustive and manipulative care of up to 5 more weeks or a maximum of 12 more visits, whichever occurs first. Health Options will confirm receipt of the report and notify the Member and Doctor of Chiropractor Medicine or doctor of osteopathic medicine.

After a maximum of 24 visits for the same or a related condition, a Member's continuing therapeutic, adjustive and manipulative treatment requires Prior Approval by Health Options before we will pay additional Benefits.

Including visits from all Doctors of Chiropractor Medicine and doctors of osteopathic medicine who are Specialists, a Member may not receive Benefits for more than 40 visits for therapeutic, adjustive and manipulative services in a Calendar Year.

**G. 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.

**H. Prior Approval**

1. <u>Introduction</u>

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 Use Disorder 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 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 medications dispensed by a Pharmacy
   Medications requiring Prior Approval, to include high cost infusions and injections that are dispensed by a pharmacy, must go through our pharmacy prior approval process. These will be noted on the Formulary.

b. Prior Approval for medications dispensed by a Provider
   Certain high cost infusions and injections that are dispensed by a Provider must go through the medical management Prior Approval process. These medications will be noted in Health Options website.

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-Network Provider, if you fail to obtain Prior Approval for a service requiring 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.

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

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

   - Notification to Health Options is required within 48 hours for all inpatient admissions.
   - Notification is required for OB Care (pregnancies/deliveries) within 24 hours of Observation Stay or within 48 hours of Admission; Prior Approval is required for all extended OB stays (beyond 48 hours vaginal delivery and 96 hours for cesarean section). Approval for OB stays will be approved consistent with Guidelines for Perinatal Care published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology.
   - Notification to Health Options is within 24 hours of Observation stays.
     - Non-OB Observations: Prior Approval rules and policies apply to procedures and services provided during an Observation stay. Non-OB Observation stays are limited to 48 hours at which time the member is admitted or discharged to a lower level of care.
   - If notification or Approval is not requested within the required timeframe Community Health Options may deny benefits for the period prior to the request.
   - Notification is required for inter-facility ambulance transportation to the nearest facility capable of providing the appropriate level of care.

b. Types of services that generally require Prior Approval or submission of clinical documentation for clinical review. This list represents service categories that require Prior Approval but is not all-inclusive. For full details visit **https://www.healthoptions.org/health-care-professionals/professional-document-and-forms/**

   - Prior Approval is required for all observation and inpatient admissions unless otherwise noted

- Prior Approval is required for Acute Rehabilitation, Skilled Nursing Facilities, services provided by a Home Health Agency, residential (Behavioral Health) Care, Long Term Acute Care Hospital (LTACH), and Inpatient Pediatric Feeding Program.
- Skilled Nursing Facilities, Long Term Acute Care Hospital, Acute Inpatient Rehabilitation, Home Health Agencies, Behavioral Health Services
- Advanced Imaging
- Ambulance (non-emergency: ground, air, water)
- Allergy Testing
- Assertive Community Treatment (ACT)
- Behavioral Health Services
- Cardiac Rehabilitation
- Cardiac Surgery/Cardiovascular Procedures
- Chemotherapy
- Chiropractic Care/Manipulative Therapy
- Circumcision
- Clinical Trials or Studies
- Colonoscopy
- Crisis Stabilization Unit (CSU)
- Dental and Orthognathic Related Services
- Dialysis
- Durable Medical Equipment (DME), Orthotics, Prosthetics; Oxygen Equipment and Contents
- Ear, Nose and Throat services
- Early Intervention Services
- Elective inpatient procedures and admissions
- Gastroenterology and General Surgery
- Genetic/Pharmacognenic Testing
- Genitourinary
- Hearing Aids or Repairs
- Home Health Services
- Home Infusion Services
- Hospice/Hospice Respite
- Hyperthermia Treatment
- In-home Biometric Monitoring
- Infusions/ Injections (as listed on drug formulary or Medication Prior Approval requirements)
- Intensive Outpatient Programs (IOP)
- Inpatient Pediatric Feeding Programs
- Inpatient Procedures/Admissions
- Long Term Acute Care Hospital (LTACH)
- Medications (as listed on drug formulary or Medication Prior Approval requirements)
- Mental Health Residential Treatment Center (RTC) (non-emergent)
- Molecular Diagnostics
- Neurosurgery
- New Technology
- Non-Emergency Ambulance Service
- Nuclear Cardiac/Radiologic Studies
- Nutritional Products/Services
- Occupational Therapy
- Ophthalmology Procedures
- Orthopedic Procedures
- Orthotics
- Osteopathic Manipulation
- Outpatient Electroconvulsive Therapy (ECT)
- Outpatient Procedures, Surgeries, Services (including Rehabilitation and Habilitation Services)
- Oxygen Equipment and Contents

- Pain Management Services/Injections
- Partial Hospitalization Programs (PHP)
- Physical Therapy
- Plastic, Reconstructive and/or Cosmetic Procedures
- Potentially Experimental or Investigational Services
- Prosthetics
- Psychological and Neuropsychological Testing
- Pulmonary Rehabilitation Radiation Treatment
- Reconstructive/Potentially Cosmetic Procedures
- Residential Detoxification and Rehab (non-emergent)
- Second Opinions from Non-Network Providers
- Sleep Study
- Speech Therapy
- Spinal Injections
- Surgical Procedures (Inpatient/Ambulatory Care/Outpatient Settings)
- Transplant and related services including initial consult and evaluations
- Transcranial magnetic stimulation (TMS)
- Wigs/Artificial Hair Pieces
- Wound Care Clinic
- Wound Care Products and Procedure

3. Seeking Prior Approval

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

If you use a Non-Network Provider or your services are ordered by a Non-Network 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. Failure to obtain Prior Approval for your Covered Services received from Non-Network Providers will result in a benefit reduction penalty of $500 for each type of Covered Service, per occurrence, if the services are determined by Health Options to be Medically Necessary. The benefit reduction penalty is not a covered, and will not be applied to your Deductible amount or the Maximum Out-of-Pocket.

If you seek services from a Non-Network 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-Network 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. When there is an inadequate network, balance billing does not apply.

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. Failure to notify Health Options will result in a benefit reduction penalty of $500 for each occurrence, if the services are determined by Health Options to be Medically Necessary. The benefit reduction penalty is not covered, and will not be applied to your Deductible amount or the Maximum Out-of-Pocket.

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 for urgent service requests. Written notification is sent to you or your representative and the Provider for urgent routine requests. 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.

### I. Prescription Drugs

1. <u>Formulary</u>

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. Adverse formulary changes will be made with at least 60 days' advance written notice, unless when a prescription drug is being removed from the formulary because of concerns about safety.

The formulary contains information for each drug, including the tier, and designation if Prior Approval, 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 that apply. 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.

When filling prescriptions, you must be eligible for coverage on the date the prescription is filled. Determination of coverage is made by Health Options and our Pharmacy Benefits Manager (PBM). 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/Formulary.

2. <u>Generic Drugs and Generic Substitution</u>

Our Pharmacy Benefits Manager has classified generic drugs. Generic drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug. When you are prescribed a brand name drug and a generic option is available, your pharmacy will automatically fill the prescription using the generic drug.

If, for medical reasons, you require the brand-name drug, you can request your Provider obtain Prior Approval from our Pharmacy Benefits Manager of the brand-name drug. Your Provider will need to submit clinical information to support why you need the brand-name drug instead of the generic. If Prior Approval is granted, you will pay the applicable cost associated with the brand-name drug as described on the formulary.

Your Provider can also request (or submit on your behalf) a prescription for a brand-name drug by writing "dispense as written" on the prescription. This requires the pharmacy to fill the prescription for the brand-name drug. If "dispense as written" is on the prescription, you will pay the non-preferred brand drug cost-sharing plus a 'dispense as written" penalty of the difference in price between the brand-name and generic drug. The penalty does not apply to your Out-of-Pocket costs.

3. <u>Specialty Drugs</u>

Community Health Options® has partnered with our Pharmacy Benefit Manager 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.

In order to pay the cost-sharing listed on your *Schedule of Benefits* for specialty drugs, they must be filled through our Preferred Specialty Pharmacy. The Preferred Specialty Pharmacy is established by Community Health Options and is subject to change at our discretion.

For most specialty drugs, you may 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 maximum.

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.

If you 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.

Certain specialty drugs are part of the MBM program and are not covered if filled through the Preferred Specialty Pharmacy. These specialty drugs must be approved by the MBM and filled by your Provider to ensure coverage. Refer to the Community Health Options website for further information about the specialty drugs included in the MBM program.

4. 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.

5. Exceptions to Coverage

Health Options has a process for allowing exceptions to our formulary. To obtain coverage consideration 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 or Medical Benefit Manager (MBM) 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. A prescription that requires an exception for coverage shall be considered approved up to 30 calendar days if the exception process exceeds 48 hours from the receipt of all necessary information.

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.

6. 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.

7. 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.

8. 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.

9. 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. Our review will generally be completed within 30 days. 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.

10. 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.

11. Exclusions

   The Plan does not provide Benefits for non-FDA approved drugs and certain drugs or appliances as listed in section 5 (Exclusions from Benefits) unless otherwise stated. Any services that is not listed in Section 4 (Covered Services) are not included in coverage.

### J. 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 Network Provider. You will be responsible for paying applicable cost-sharing for:

- Preventive Services rendered by non-Network Providers,
- Services that are not defined in federal law as Preventive Services, or
- 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.55. [

### K. Chronic Illness Support Program

If you have been diagnosed with hypertension (high blood pressure), diabetes, asthma, chronic obstructive pulmonary/lung disease (COPD or emphysema), or coronary artery disease (CAD), you can benefit from our Chronic Illness Support Program. We included these five conditions in this program because medical experts agree there is strong evidence that these enhanced covered services will help our Members manage these conditions for better overall health.

Chronic illness means that you will always have the diagnosis, even if you do not have any symptoms. Chronic illnesses are different from illnesses that are expected to resolve or go away. For example, gestational diabetes is not included in this program because it usually goes away when the baby is born and is not a chronic illness.

This program provides reduced Out-of-Pocket Costs (Copayments, Coinsurance, and Deductibles) when performed by a Network Provider. Select Tier 1, Tier 2 and Tier 3 preferred medications will also have reduced Out-of-Pocket Costs. The drugs selected as part of the Chronic Illness Support Program will be designated on our formulary and must be filled through the Home Delivery Program described in section 2.G.7 in order to receive the reduced cost-sharing of the Chronic Illness Support Program. All other drug tiers and drugs not designated on our formulary under

the Chronic Illness Support Program are not included as part of this program. Talk with your Provider about whether or not alternatives to higher tier drugs are available. The Chronic Illness Support Program includes Medically Necessary services for routine treatment of the above five conditions. Prior Approval requirements may apply for some services. Refer to Section 2.F for more information. The program includes:

1. Diabetes

   Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost select Tier 1 preferred generic medications and a reduction in Out-of-Pocket Cost for select Tier 2 generics and Tier 3 preferred brand medications as outlined below. On plans that apply a Deductible for Tier 2 and Tier 3 medications, the Deductible is waived and the Coinsurance or Copayment is reduced by half. On plans that have a copay for Tier 2 and Tier 3 medications, the copay is reduced by half.

   Select medications used to treat diabetes that are specified on our formulary and are approved by the federal Food and Drug Administration (FDA) are covered under this reduced Out-of-Pocket Cost benefit. Select medications included in the reduced Out-of-Pocket Cost benefit will be designated on the formulary as Chronic Illness Support Program medications and must be filled through the Home Delivery Program described in section 2.G.7. Medications we specify for inclusion under this program are among the most effective and of the highest value to treat the Chronic Illness as determined by us.

   The following services related to diabetes are covered with $0 Out-of-Pocket Cost when performed by a Network Provider (unless otherwise noted):

   - Office visits to a Primary Care Provider for routine management of diabetes
   - Endocrinology consultation and management of diabetes
   - Podiatry consultation for routine diabetic foot care
   - Nutritional counseling, diabetes education and behavioral modification counseling
   - Diabetic eye exam will be covered once a year
   - One glucometer each year as specified on the formulary and dispensed through our Home Delivery Program
   - Glucose test strips listed on formulary and dispensed through our Home Delivery Program: up to 50 every 30 days or 150 every 90 days at $0 Out-of-Pocket Cost.
   - Laboratory services linked to a diabetes primary diagnosis code and considered routine for the management of diabetes.

   Please note, if you have complications from diabetes and use an emergency department, have a Hospital stay, or get treated for heart or kidney problems, the usual and customary Plan costs for these services apply, and will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

   Insulin pumps and supplies are considered Durable Medical Equipment (DME).

2. Hypertension

   Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost for select Tier 1 preferred generic medications and a reduction in Out-of-Pocket Cost for select Tier 2 and Tier 3 preferred brand medications as outlined below. On plans that apply a Deductible for Tier 2 and Tier 3 medications, the Deductible is waived and the Coinsurance or Copayment is reduced by half. On plans that have a copay for Tier 2 and Tier 3 medications, the copay is reduced by half.

   Select medications used to treat hypertension that are specified on our formulary and are approved by the FDA are covered under this reduced Out-of-Pocket Cost benefit. Select medications used to treat hypertension that are specified on our formulary and are approved by the FDA are covered under this reduced Out-of-Pocket Cost benefit. Select medications included in the reduced Out-of-Pocket Cost benefit will be designated on the formulary as Chronic Illness Support Program medications and must be filled through the Home Delivery Program described in section 2.G.7. Medications we specify for inclusion under this program are among the most effective and of the highest value to treat the Chronic Illness as determined by us.

   The following services related to hypertension are covered with $0 Out-of-Pocket Cost when performed by a Network Provider:

   - Office visits to a Primary Care Provider for routine management of hypertension
   - Office visits for consultation and management specifically for a diagnosis of hypertension with cardiology or nephrology Specialists

- Laboratory services that are linked to a hypertension primary diagnosis code and considered routine for the management of hypertension.

Please note, if you have complications from hypertension and use an emergency department, have a Hospital stay, or get treatment for heart and kidney disease, services will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

3. Asthma/Chronic Obstructive Lung Disease (COPD)/Emphysema

Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost for select Tier 1 preferred generic medications and a reduction in Out-of-Pocket Cost for select Tier 2 and Tier 3 preferred brand medications as outlined below. On plans that apply a Deductible for Tier 2 and Tier 3 medications, the Deductible is waived and the Coinsurance or Copayment is reduced by half. On plans that have a copay for Tier 2 and Tier 3 medications, the copay is reduced by half.

Select medications used to treat asthma & COPD that are specified on our formulary and are approved by the FDA are covered under this reduced Out-of-Pocket Cost benefit. Select medications included in the reduced Out-of-Pocket Cost benefit will be designated on the formulary as Chronic Illness Support Program medications and must be filled through the Home Delivery Program described in section 2.G.7. Medications we specify for inclusion under this program are among the most effective and of the highest value to treat the Chronic Illness as determined by us.

The following services related to asthma/COPD/emphysema are covered with $0 Out-of-Pocket Cost when performed by a Network Provider:

- Office visits to a Primary Care Provider for routine management of asthma/COPD/emphysema
- Immunotherapy for Members diagnosed with asthma to reduce impact and severity of allergic reactions
- Inhaler adjuncts (e.g., spacer) as specified on the formulary and dispensed through our Home Delivery Program
- Office visits with pulmonologist for consultation and management when associated with a diagnosis of asthma, COPD or emphysema
- Diagnostic testing: pulmonary function test once per year, home oxygen therapy assessment
- Asthma education: allergens/triggers, asthma action plan and behavioral modification counseling
- Pulmonary rehabilitation and ongoing exercise program for moderate to severe COPD.
- Laboratory tests services that are linked to asthma or COPD primary diagnosis code and considered routine for the management of the diagnosed condition, e.g., allergy sensitivity testing, Arterial Blood Gas (ABG)

Please note, if you have complications from asthma or COPD, and use an emergency department, have a Hospital stay, or get lung resection/transplant, services will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

4. Coronary Artery Disease (CAD)

Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost for select Tier 1 preferred generic medications and a reduction in Out-of-Pocket Cost for select Tier 2 and Tier 3 preferred brand medications as outlined below. On plans that apply a Deductible for Tier 2 and Tier 3 medications, the Deductible is waived and the Coinsurance or Copayment is reduced by half. On plans that have a copay for Tier 2 and Tier 3 medications, the copay is reduced by half.

Select medications used to treat CAD that are specified on our formulary and are approved by the FDA are covered under this reduced Out-of-Pocket Cost benefit. Select medications included in the reduced Out-of-Pocket Cost benefit will be designated on the formulary as Chronic Illness Support Program medications and must be filled through the Home Delivery Program described in section 2.G.7. Medications we specify for inclusion under this program are among the most effective and of the highest value to treat the Chronic Illness as determined by us.

The following services related to CAD are covered with $0 Out-of-Pocket Cost when performed by a Network Provider (unless otherwise noted):

- Office visits to a Primary Care Provider for routine management of CAD
- Cardiology consultation and routine management of CAD
- Electrocardiogram (ECG)
- Cardiac rehabilitation (Deductible is waived and the Coinsurance is reduced by half)

- Laboratory services linked to a hyperlipidemia primary diagnosis code and considered routine for the management of CAD.

Cardiac rehabilitation related to CAD is covered at a 50% reduction in cost-sharing when performed by a Network Provider.

Please note, if you have complications from CAD and use an emergency department, have a Hospital stay, or get a cardiac procedure not listed above (e.g., cardiac stress test, cardiac catheterization, echocardiogram, intravascular ultrasound, nuclear perfusion imaging, PET (positron emission tomography) imaging, angioplasty, coronary artery bypass graft), services will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

If you pay for a service that you think should be covered under the Chronic Illness Support Program, or if you have questions about the program, contact Member Services at 1-855-624-6463.

### L. Pediatric Dental Coverage

This Plan provides Benefits for pediatric dental services through Delta Dental Plan of Maine, Inc. Dental benefits are only available to persons who are 18 years of age or less as of the effective date of coverage, except as provided in this Agreement. An eligible Member may choose to go to any dentist and receive some level of Benefits, but Members receive the best value when visiting a Delta Dental PPO Dentist. For additional information, please consult the Covered Services section of this Member Benefit Agreement for full details. See the Dental Benefit Agreement in the Appendix for full details of this coverage.

### M. Comparable Out-of-Network Healthcare Services

If a member obtains certain comparable health care services: physical & occupational therapy services; radiology & imaging services; laboratory services; infusion therapy services from a non-contracted provider located in Maine, New Hampshire or Massachusetts, that is enrolled in the MaineCare program and participates in Medicare, then you may qualify to have Out-of-Network services applied to your In-Network benefits. Contact Member Services for additional information and a form is available on our website.

## 3. ENROLLMENT AND ELIGIBILITY

**If your Employer Group enrolled through SHOP, the Employer Group's and your eligibility for coverage under this Agreement shall be determined by the Federally-Facilitated Small Business Health Options Marketplace (SHOP). The SHOP determines eligibility criteria and enrollment periods for Subscribers and Dependents. The SHOP also processes applications for enrollment for coverage under the Plan. You will need to use the SHOP Employee Application to submit your enrollment information to SHOP.**

**If your Employer Group enrolled directly with Community Health Options, you will need to submit your enrollment information through your Employer Group. Any changes to that enrollment will be reported to Health Options through your Employer Group. Health Options does not exclude part-time employees. A part-time employee is defined by the applicable State and Federal laws.**

This section of the Agreement explains who is eligible for coverage under the Plan. The Employer Group Agreement between Community Health Options® ("Health Options") and your Employer Group contains terms and conditions regarding who is eligible for coverage under the Plan and when coverage is effective. There are two types of people who are usually eligible for coverage: Subscribers and Dependents.

### A. Enrollment

You can enroll under the Plan during your Employer Group's 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. Annual Open Enrollment

   You may obtain coverage for yourself and Dependents during the annual Open Enrollment period, which lasts at least 30 days. For Employer Groups enrolled through SHOP, the SHOP determines when this period is. The SHOP will give you notice before the annual Open Enrollment period. For Employer Groups enrolled directly with Health Options, your Employer Group will give you notice before the annual Open Enrollment 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 your Employer Group.

To take advantage of a Special Enrollment Period, you must complete the enrollment process through your Employer Group. 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 Health Options receives premium payment and the completed enrollment information.

### B. Subscriber and Dependent Eligibility

1. Subscribers

To be eligible as a Subscriber, you must meet your Employer Group's eligibility requirements. Your enrollment must be submitted electronically via SHOP or Health Options' Enrollment Portal by your Employer Group, and the SHOP/Health Options must determine that you are eligible for coverage under the plan as a Subscriber.

2. Dependent Eligibility

Subscribers must apply for coverage for Dependents directly with the Employer Group. Unless your Employer Group has specified different eligibility criteria for Dependents, and when they become eligible for coverage, Dependents must fall into one of the following categories:

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 be removed from the policy at the end of the birth month unless documentation is provided to the Marketplace and Health Options that shows the Dependent meets other requirement described below.**
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 SHOP may require the Subscriber or Employer Group 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

You will be informed of the effective date by your Employer Group. You will not receive Benefits for any services (including inpatient stays), supplies, or equipment provided to you or received by you before the 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))

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

b. Birth, Adoption or Legal Guardianship

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 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.

i. 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 enrollment to us or the Marketplace, as applicable, within 60-days from birth.

ii. Legal Guardianship

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

iii. 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 enrollment is received within 60 days from the date of the court order or event.

iv. 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 SHOP, 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 enrollment 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.

Additional information for Employer Groups enrolled through SHOP:

You may add yourself and/or your Dependents if you select coverage through the SHOP within 60 days after the following events:

i. In the event of unintentional, inadvertent, or erroneous enrollment/non-enrollment caused by the SHOP or the U.S. Department of Health and Human Services;
ii. In the event that your insurance carrier providing coverage through the SHOP violates a material provision of your coverage contract;
iii. In the event you gain access to a new health insurance company through a SHOP because you make a permanent move;
iv. In the event you demonstrate exceptional circumstances to the SHOP; or
v. In the event that the SHOP determines that you were not enrolled in certain coverage, were not enrolled in the coverage that you chose, or you did not receive certain tax credits or Out-of-Pocket Costs reductions as a result of misconduct by an entity other than the SHOP.

If you are an Indian (as defined by section 4 of the Indian Health Care Improvement Act) you may change your coverage one time per month as permitted by SHOP. In all cases, your coverage effective date will be determined by the date you complete the enrollment process.

2. Eligibility Changes

   It is the responsibility of the Employer Group to promptly inform Health Options and the SHOP, 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

Your Employer Group 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. Enrollments as the result of a Special Enrollment Period or outside of the annual Open Enrollment, may require retroactive premium adjustments back to the date of the event or effective date of coverage.

If your Employer Group does not pay the Premium in full when due, there will be 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 may terminate your coverage under the Plan. Community Health Options may allow for reinstatement of the Employer Group as described in the Group Agreement. We reserve the right to take necessary steps to collect outstanding Premiums.

### E. 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 (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 Amount for such services. Deductible amounts are limited to the Maximum Allowable Amount. No Benefits are available for amounts that exceed Community Health Options' ("Health Options") Maximum Allowable Amount.

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 Service 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:

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

   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 (also known as balance billing). When there is an inadequate network, balance billing does not apply.

   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 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. For non-emergency services, the Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing, or water transportation. For emergency services, we encourage your Provider(s) to coordinate with our Medical Management team in selecting an Air Ambulance provider, when possible. Community Health Options has contracts with certain Air Ambulance providers and the Allowed Amount for non-Network Air Ambulance Providers may be based on those contracts. This means you could be balance billed for charges that exceed the Allowed Amount. When there is an inadequate network, balance billing does not apply.

   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. Ambulatory services do not include overnight stays (past midnight).

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:
   c. All stages of reconstruction of the breast on which a mastectomy has been performed;
   d. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   e. 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.
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 and Therapeutic, Adjustive and Manipulative Services. The Plan provides Benefits for Medically Necessary chiropractic and osteopathic 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. No benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in conjunction with an active course of treatment.

    Chiropractic benefits are limited to 40 visits per Member per Calendar Year.
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. 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.

    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 Network Provider. This includes, but is not limited to, barrier methods, hormonal methods, surgical implanted and over the counter devices. Certain contraceptives are only covered without cost-sharing if acquired through a pharmacy. Contact Member Services at 855-624-6463 to confirm preventive coverage without cost-sharing for contraceptives.

    The Plan provides Benefits for abortions.

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, including dental implants for treatment of oral cancer, or any type of artificial tooth roots, including when in conjunction with dental Prostheses. Fluoride carriers are not covered by the Plan.

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.55 will be considered Diagnostic Services. Services covered under this section include the services of a Physician with a specialty in radiology.

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. 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.

    Coverage for glucometers is limited to the pharmacy benefit.

    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 hearing aids, over-the-counter batteries and replacement batteries are not covered, except for implantable medical devices.

    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 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.

    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 30 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 (known as balance billing), in addition to the applicable cost-sharing (Deductible, Coinsurance or Copayments). When there is an inadequate network, balance billing does not apply.

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

    a. The amount negotiated with In-Network Providers for the Emergency service;
    b. 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
    c. 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. If you continue to get care from an Out-of-Network Provider, 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. For adult Members 19 years of age and older, the Plan provides Benefits for one routine eye exam every two (2) years. Adult eye exams are not "Essential Health Benefits" and do not accumulate toward your Out-of-Pocket Limits.

    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.

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.
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 or submersion.
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.

    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.
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.
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.
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 and 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.

Health Options may require that a 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*.

    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 Medically Necessary 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.

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

    If you receive services from a Community Mental Health Center or Substance Use Disorder 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 Use Disorder treatment services when Medically Necessary:

    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 Use Disorder condition requiring immediate and acute treatment.

    Outpatient visits for Substance Use Disorder conditions may be furnished during the acute detoxification stage of treatment or during stages of rehabilitation.

    The Member cost-sharing will be waived for the first 3 outpatient office visits in the Plan Year to an In-Network mental health or Substance Use Disorder provider.
45. Morbid Obesity. The Plan provides Benefits for surgery for an intestinal bypass, gastric bypass, or gastroplasty for treatment of Morbid Obesity.

    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.
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. 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, to the newborn.

    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

    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.

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. Your Provider will work with our registered nurses and Physician advisors to evaluate your condition and determine the Medical Necessity of a transplant procedure.

    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, when Medically Necessary, 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.

    Speech Therapy Benefits are limited to 20 visits per Member per Calendar Year. Physical Therapy and Occupational Therapy Benefits are limited to 20 total combined visits per Member per Calendar Year.

52. Palliative Care. The Plan provides Benefits for Palliative Care Conversations with your Provider so you can discuss your personal values and preferences of how you want relief from the symptoms and stress of a serious illness. Palliative care focuses on improving life and providing comfort to people of all ages with serious, chronic and/or life

threatening illnesses. While often associated with hospice care, it is not the same as Hospice as it can include curative treatment.

53. 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.

54. 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. 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.

55. 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*. Pediatric immunizations are eligible with no Out-of-Pocket cost only when obtained from your Primary Care Provider. 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.

56. 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. Because the United States Preventive Services Task Force (USPSTF) does not rate prostate cancer screenings as "A" or "B" this service is provided at applicable Plan cost-sharing.

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

57. 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.

58. 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.

59. 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.

60. Second Opinions. The Plan provides Benefits for second opinions when provided by a Network Provider with no practice association with the original Provider.

61. 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.

62. 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.

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 a network home sleep study Provider.

63. 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.

    Physical Therapy, Occupational Therapy, and Speech Therapy benefits are limited to a total of 60 combined visits (outpatient) per Member per Calendar Year.

    A Member may obtain Medically Necessary speech therapy, physical therapy, occupational therapy for a maximum of 12 visits by submitting a complete report to Health Options within 10 working days after the first consultation with the Member. Health Options will not provide Benefits for physical therapy, occupational therapy and speech therapy services and the Member will not be liable for any unpaid fees if the report is not submitted. Health Options will confirm receipt of the report and notify the Member and Provider.

    The report by the treating Provider shall contain:

    - The Member's complaint including the nature of the injury or condition;
    - Related history;
    - Examination;
    - Initial diagnosis;
    - Number of visits completed to date in the calendar year; and,
    - Treatment plan.

    Within 10 working days after the commencement of additional visits the Provider shall submit a plan which includes Member progress and outlining a treatment plan for Medically Necessary care beyond the initial 12 visits or, if fewer visits were requested, the number of visits included in the initial report. Prior Approval is required from Health Options before we will pay additional Benefits for Medically Necessary physical therapy, occupational therapy and speech therapy.

    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.

64. 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.

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 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 listed exclusions are not all-inclusive and are in addition to other exclusions listed and not listed in this Agreement. Unless a service is listed as a covered benefit in Section 4, it is likely not covered. If you pay for a non-Covered Service, it will not count toward your Out-of-Pocket Cost limits.

1. 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.
2. Administrative Examinations or Services. The Plan does not provide Benefits for physical examinations and immunizations required for:
   a. enrollment in an insurance program,
   b. enrollment in an educational institution,
   c. a condition of employment,
   d. recruitment to armed forces,
   e. licensing of any kind,
   f. admission to a prison or residential institution,
   g. immigration or naturalization purposes,
   h. premarital examinations,
   i. participation in sport,
   j. issuance of a medical certificate,
   k. disability determination,
   l. paternity testing,
   m. adoption services,
   n. blood-alcohol or blood-drug testing, or
   o. other administrative purposes.
3. 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*.

4. 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.
5. Charges Above the Maximum Allowable Amount. No Benefits are provided for charges above the Maximum Allowable Amount determined by Community Health Options®.
6. 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.
7. Cosmetic Services. Except for reconstructive services described under section 4.B.58, the Plan does not provide Benefits for Cosmetic Services.
8. 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.
9. Custodial Care. The Plan does not provide Benefits for services, supplies, or charges for Custodial Care, convalescent care or rest cures.
10. 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. Dental implants for treatment of oral cancer are not covered. Fluoride carriers are not covered by the Plan.
11. 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.
12. 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 to treat Members who are immune-compromised or diabetic as Medically Necessary
    - Legend (prescription) drugs that are not deemed Medically Necessary
    - Experimental or Investigational drugs including administration costs
    - 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
- 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

13. 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. The Plan does not provide Benefits for Durable Medical Equipment or Medical Supplies that cost more than meets the Member's medical needs. For more information contact Member Services at 1-855-624-6463.
14. Erectile or Other Sexual Dysfunction. The Plan does not provide Benefits for any supplies, services, surgery 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, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
15. 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.
16. 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.
17. 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. This includes pediatric immunizations administered through the State of Maine's Immunization Program.
18. 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.
19. 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.
20. 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.
21. 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. Regardless of age, no Benefits are provided for cochlear implants, replacement parts, or cochlear implant batteries. No Benefits are provided for the replacement of lost, stolen, or damaged Hearing Aids.
22. Infertility; Infertility Prevention; Surrogacy. The Plan does not provide Benefits for fertility drugs, Diagnostic Services, procedures, treatment, or other services or costs related to Infertility or anticipation of potential infertility. This exclusion applies to services related to banking sperm or egg and embryo freezing as well as 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).

23. 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.
24. 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.
25. 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:

    a. Telephone access to your Provider 24 hours a day, 7 days a week;
    b. Having a Provider accompany you to appointments with Specialists;
    c. Guaranteed same-day appointments when not Medically Necessary; and
    d. 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.
26. 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 Provider is not a Covered Service. This exclusion includes, but is not limited to, trips to an 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 facility or long-term dwelling that is not an acute care hospital, such as a nursing facility, physician's office, or your home.
27. 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.
28. Observation Care: The plan does not provide Benefits for services that are considered inappropriate use of Observation service.
    a. Provider, Member, family/caregiver convenience;
    b. Routine preparation, performance and/or recovery for diagnostic or surgical procedures;
    c. Administration of blood products;
    d. Cases routinely cared for in the Emergency Department or Outpatient Department;.
    e. Routine recovery and post-operative care after routine outpatient surgery;
    f. Observation following an uncomplicated treatment or procedure;
    g. As a standing order following outpatient surgery.
29. Orthognathic Surgery. The Plan does not provide Benefits for Orthognathic Surgery, except as covered under section 4.B.58.
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. This exclusion includes over-the-counter batteries for Medically Necessary devices.
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, but no limited 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.63.

    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, including implants that support mandibular prosthesis. 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 or higher technology (e.g. titanium, microprocessor) than meets the Member's medical needs. 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 Gender Reassignment. The Plan does not provide Benefits for services to reverse voluntarily induced surgical gender reassignment.
43. Reversing Voluntarily Induced Sterility. The Plan does not provide Benefits for services to reverse voluntarily induced sterility.
44. Routine Circumcisions. We do not provide Benefits for routine circumcisions.
45. 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.
46. 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.
47. 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.
48. Services Received Outside of the United States. The Plan does not provide Benefits for Services received outside of the United States except for Emergency Services which will be paid in accordance with this Agreement at the Maximum Allowable Amount. If you need additional coverage outside the United States, you should purchase travel medical insurance.
49. 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.
50. Spider Veins. The Plan does not provide Benefits for treatment of telangiectatic dermal veins (spider veins) by any method.
51. 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.
52. 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.
53. Temporomandibular Joint Syndrome (“TMJ”). The Plan does not provide Benefits for services for the evaluation, diagnosis, or treatment of TMJ, whether medical or surgical.
54. 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.
55. 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. Network Providers

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

If you receive services from a Network Provider that are not Covered Services, you will be responsible for the cost of those non-Covered Services. If a Network 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-Network Providers

If you receive Covered Services from a Non-Network 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-Network Provider, the Plan will pay Benefits up to the Maximum Allowable Amount. We will pay Benefits directly to you or to the Non-Network 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-Network 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-Network Provider, the Plan will provide Benefits at Network Provider Out-of-Pocket Costs based on the Maximum Allowable Amount, as determined by us, for the services received.

In the event of a Surprise Bill Health Options will reimburse an Out-of-Network provider at the average network rate under an enrollee's plan unless the carrier and provider agree otherwise.

**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. Once the full Family Deductible is met, by two or more family members or a combination of family members, services for all covered family members are subject to applicable Coinsurance and Copayments 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. **Charges from Non-Network Providers above the Maximum Allowable Amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Network 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 the full Family Out-of-Pocket Maximum is met by one family member or a combination of family members, the Plan pays 100% of the Maximum Allowable Amount for Covered Services for the family. 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-Network Providers above the Maximum Allowable Amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Network 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. Network Providers vs. Non-Network Providers

Please note that your Out-of-Pocket Costs for Covered Services may be higher when Covered Services are provided by a Non-Network 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 Network Provider and a Non-Network Provider cannot be more than 20%. When you receive services for a Medical Emergency, your Out-of-Pocket Costs (up to the Maximum Allowable Amount determined by Health Options) will be at the Network Provider level whether you see a Network Provider or a Non-Network Provider. **Charges from Non-Network Providers above the Maximum Allowable Amount will not apply to your cost-sharing and will be your responsibility, if the Non-Network Provider chooses to bill you (known as balance billing). This means you may have financial responsibility greater than the cost-sharing described on your Schedule of Benefits.** When there is an inadequate network, balance billing does not apply.

Covered Services applied to the Non-Network Deductible and/or Out-of-Pocket Maximum will not apply to the Network Deductible and/or Out-of-Pocket Maximum. Covered Services applied to the Network Deductible and/or Out-of-Pocket Maximum will not apply to the Non-Network Deductible and/or Out-of-Pocket Maximum.

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

Network Providers will file claims directly with the Plan. Members may need to submit a claim for reimbursement for services from a Non-Network 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 Network 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.** When there is an inadequate network, balance billing does not apply. 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." 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.

### C. Subrogation

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. 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. Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien.

### 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, we recommend that you contact a Member Services Associate before filing an Appeal. Sometimes, an issue 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. Please contact Member Services if you have questions. Health Options will respond to you as quickly as we can. Most complaints can be investigated and responded to within 30 days. If you disagree with our response, you may be able to file an Appeal.

If you are not satisfied with the results of your Complaint or Appeal, you have the right to submit a complaint 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)

### 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 cultural 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: 207-402-3947

   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:

   i. 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;
   ii. 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;
   iii. 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;
   iv. The title and qualifications of the person who conducted the review;
   v. 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;
   vi. How to obtain a second level review;
   vii. 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
   viii. 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.

**C. 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 SHOP 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") or the SHOP, as applicable, 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 timely paid 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) discontinuance of coverage by Health Options in the service area, or (e) failure of the Employer Group to meet eligibility requirements.

### B. Termination by Employer Group

If you Employer Group withdraws from coverage with Community Health Options or the SHOP, your coverage will be terminated.

### C. Termination by Health Options or SHOP

Health Options or SHOP may terminate this Agreement and coverage under the Plan for the following reasons:

1. Failure to meet all of the eligibility requirements for coverage;
2. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact;
3. Non-payment of Premium as provided in section 3; and
4. If (1) you switch coverage, or (2) the Plan is terminated or no longer certified by the SHOP. Any termination made under this section will be made as required by law and/or the SHOP.

If we terminate this Agreement and your coverage under this section, we will give you at least 10 days' notice before termination, as required by law and section 3. Subscribers that pay a portion of the cost of their insurance coverage via payroll deduction have a right to designate a third party to received 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.

We will refund to the Employer Group Premiums paid for periods after the date of termination.

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. Health Options will provide 30 days' written notice prior to rescinding coverage.

### D. Continuation of Coverage

If your Agreement terminates, Maine and federal law may give you the ability to continue coverage for you and your Dependents. These rights are summarized below. You may contact Member Services, your Employer Group, or the Maine Bureau of Insurance if you have questions or want more information.

1. Extended Coverage for Total Disability

   You may be eligible to have your coverage extended under the Plan if your Employer Group terminates your Plan coverage and you are totally disabled on the date of termination. However, if your Employer Group replaces your coverage, then you may not be eligible.

   Your coverage will be extended for the treatment of the condition causing the total disability until the earlier of:

   a. The date on which the total disability ends; or

   b. Six months from the date your coverage would have ended.

   For purposes of this section, the term "total disability" means that as a result of an injury or sickness, you are unable to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. We may require your Provider to send us proof of your condition.

   The terms and conditions of your extended coverage will apply. You will not be charged a Premium. If you become covered under replacement coverage, the replacement coverage must pay as primary coverage and the replaced coverage must pay as secondary coverage for the covered expenses directly relating to the condition causing total disability during the extension of benefits under this section.

   After discontinuation of the coverage by your Employer Group, the Plan is liable only for (1) accrued liabilities, and (2) extensions of coverage for the condition relating to your total disability as provided under this section.

2. COBRA and "mini-COBRA"

   If your coverage terminates, you may be eligible for continued coverage under COBRA. You should contact your Employer Group to determine whether you are eligible for COBRA continuation coverage. Your Employer Group is responsible for arranging your COBRA continuation coverage.

   Under Maine law, insurers are required to permit continued coverage in certain situations when the federal COBRA law does not apply. This is sometimes called "mini-COBRA." You may contact Member Services for more information at 855-624-6463.

3. Military Service

   Certain military personnel and their Dependents may be eligible for continuation coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are not working because of active U.S. military service, you may be able to obtain continuation coverage for yourself and your Dependent(s). Additionally, when you return to your employment, coverage for you and your Dependent(s) under the Plan may be reinstated. Please contact your Employer Group if you have questions about your USERRA rights.

## 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 Network Providers. Network Providers are independent contractors. They are not agents or employees of Health Options. Network Providers may not modify this Agreement or the *Schedule of Benefits*. Only Health Options may modify this Agreement as provided under section 10.C. Network Providers cannot make binding promises on behalf of Health Options.

Health Options may change its arrangements with Network Providers, including addition and removal of Network Providers. Health Options will try to give you at least 60 days' notice before Health Options removes a Network 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.

### 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:

a. Obtaining and sharing information with your Providers so we can perform Prior Approval activities;
b. Conducting quality activities;
c. Obtaining information from Providers so we can properly pay Benefits; and
d. 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.

Acute Rehabilitation. Services provided to treat traumatic injury in an acute rehabilitation hospital.

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). When there is an inadequate network, balance billing does not apply.

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.

Doctor of Chiropractic Medicine. 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 Network 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 Use Disorder 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 Use Disorder 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:

a. Can withstand repeated use;
b. Is used only to serve a medical purpose;
c. Is appropriate for use in the patient's home;
d. Is not useful in the absence of illness, injury or disease; and
e. 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:

a. placing the enrollee's physical and/or mental health in serious jeopardy;
b. serious impairment to bodily functions; or
c. 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:

a. Drugs classified by the FDA as treatment investigational new drugs;

b. Services involved in clinical trials;
c. Devices that have an FDA investigational device exemption; and
d. Devices for which the FDA has limited access or approval.

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.

Home Health Care Services. Services provided within the home if hospitalization or confinement in a residential treatment facility would otherwise be required.

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.

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:

a. Being unable to conceive despite engaging in frequent sexual relations without contraception for a year or more; or
b. 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 Network Provider. Visits or services with Network Providers are Covered as In-Network.

Inpatient. A Member admitted to a Hospital, Skilled Nursing Facility, or residential treatment facility for an overnight (crosses at least one midnight) 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 Network 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:

a. 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;
b. Serious impairment to bodily functions;
c. Serious dysfunction of any bodily organ or part; or
d. 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:

a. Consistent with generally accepted standards of medical practice;
b. Clinically appropriate in terms of type, frequency, extent, site, and duration;
c. Demonstrated through scientific evidence to be effective in improving health outcomes;
d. Representative of best practices in the medical profession; and
e. 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.

Medical Benefit Manager (MBM). Administrator of a prescription drug program for drugs dispensed by a Provider.

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.

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

Non-Network 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-Network Providers.

Observation: Active, short-term medical and/or nursing services performed on an acute care facility's premises, that include the use of a bed and monitoring by that acute care facility's staff, to observe a Member's condition to determine if the Member requires an inpatient admission to the facility.

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.

Palliative Care Conversations. Palliative Care Conversations are up to 30 minute discussions with your Provider about your personal values and preferences of how you want relief from the symptoms and stress of a serious, chronic and/or life threatening illness.

Pharmacy Benefits Manager (PBM). Administrator of a prescription drug program.

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.

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 Network 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 (Network Providers), and (ii) other health care institutions, facilities, agencies, and professionals as required by law.

Provider Directory. A list of Network 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 Network 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:

a. Be operated pursuant to law;
b. Approved for payment of Medicare benefits, or otherwise qualified to receive approval for payment of Medicare benefits;
c. Primarily engaged in providing, in addition to room and board, skilled nursing care under the supervision of a duly licensed Physician;
d. Provides continuous 24-hours-a-day nursing service by or under the supervision of a registered nurse; and
e. 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/Stabilization. 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 Use Disorder Treatment Facility. A residential or nonresidential institution that meets all of the following requirements:

a. Licensed or certified as a Substance Use Disorder Treatment Facility;
b. Provides care to one or more patients for alcoholism and/or drug dependency; and
c. Is a freestanding unit or a designated unit of another licensed health care facility.

Surprise Bill. Is defined as a bill for health care services, other than emergency services, received by an enrollee for services rendered by an out-of-network provider at a network provider during a service or procedure performed by a network provider, or during a service or procedure previously approved or authorized by the carrier. A “surprise bill” does not include a bill for health care services received by an enrollee if a network provider was available and the enrollee knowingly elected to obtain the services from an out-of-network provider.

Telemedicine. The delivery of health care services for the purpose of diagnosis, consultation or treatment rendered via HIPAA-compliant, real-time interactive audio and video. An interactive audio and video telecommunications system that permits real-time communication between the distant and originating site must be employed. Telemedicine does not include the use of audio-only telephone, facsimile machine, texting or e-mail.

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 (UCR). 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.

## 12. APPENDIX A – DESCRIPTION OF DENTAL BENEFITS PROGRAM

Dental benefits are only available to persons who are 18 years of age or less as of the effective date of coverage, except as provided in the Member Benefit Agreement.

Dental benefits are administered by Delta Dental Plan of Maine on behalf of Community Health Options®.

### 1. Introduction

The dental benefits program of Community Health Options® ("Health Options") is administered by Delta Dental Plan of Maine d/b/a Northeast Delta Dental. We'd like you to know something about Delta Dental...

Delta Dental is a not-for-profit organization which was established by Dentists to make Dental Care more open to the public.

Delta Dental is connected with Delta Dental Plans Association ("DDPA") which provides Dental Care programs in all states and U.S. territories.

Most Dentists in Maine participate with Delta Dental through Participating Agreements. Also, there is a network of Delta Dental Participating Dentists available to you across the nation.

Please take advantage of your dental benefits because good oral health is an important part of your overall general health. You are also encouraged to get your Dental Care from a Delta Dental PPO Dentist to benefit the most from your plan.

The dental benefits offered by Delta Dental pursuant to this policy are governed by certain policies and procedures of the US Department of Health and Human Services ("HHS") and the Maine Bureau of Insurance (the "Maine Bureau") for certified plans offered through the federally-facilitated Health Insurance Marketplace (the "FFM"). To the extent applicable, Delta Dental intends to comply with the policies and procedures of the applicable state and federal regulators in the offering and administration of the dental benefits governed by this plan.

### 2. Defined Words

At the end of this Appendix you will find a Glossary of defined words used in this Appendix. You will also find elsewhere in this Appendix other defined words. These defined words begin with capital letters. It is important that you understand what these defined words mean. If a word is not defined in this Appendix, please consult the Glossary in the Agreement.

When this Appendix uses the words "we," "us," and "our," this means Delta Dental and its designated affiliates. When this Appendix uses the words "you" and "your," this means the Subscriber and all Members and Dependents.

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

### 3. What Your Plan Pays

Coverage: The coverage selected for your dental benefits program uses Delta Dental's PPO network of Participating Dentists. This Delta Dental PPO network program allows you to go to any Dentist of your choice and receive a level of benefits for Covered Services, but you will generally receive the best value from your plan if you visit a Delta Dental PPO Dentist. For the purpose of determining applicable Out-of-Pocket Cost, only Delta Dental PPO Dentists shall be deemed to be "Plan Providers" under the Agreement. Only your payments to Delta Dental PPO Dentists shall accrue to the Out-of-Pocket Costs for Plan Providers as specified in your *Schedule of Benefits*.

Your plan's payment is based on the "allowed charge" for a Covered Service received. The allowed charge is determined by whether the provider of the services is a Delta Dental PPO Dentist, participates with Delta Dental as a Premier Dentist, or does not participate with Delta Dental.

a. If the Dentist is a Delta Dental PPO Dentist, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Copayment, Coinsurance and payment for services not covered under your plan. The Dentist cannot receive in total more than Delta Dental's allowance for PPO Dentists and has agreed not to bill you for more than that amount.
b. If the Dentist is not a Delta Dental PPO Dentist, but is a Delta Dental Premier Dentist, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Copayment, Coinsurance,

payment for services not covered under your plan, and any difference between your plan's payment and Delta Dental's allowance for Premier Dentists in the geographic area in which the services were provided. The Premier Dentist cannot receive in total more than such allowance for Premier Dentists and has agreed not to bill you for more than that amount. Payments you make to Premier Dentists do not count toward the Maximum Out-of-Pocket (MOOP) for Pediatric Enrollees.

c. If the Dentist is a Non-Participating Dentist or Other Dental Provider, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Copayment, Coinsurance, payment for services not covered under your plan, and any difference between your plan's payment and the provider's charge for the service. It is in your best interest to discuss what the charge will be before receiving the service. Any payments you make to Non-Participating Dentists do not count toward the Maximum Out-of-Pocket (MOOP) for Pediatric Enrollees. You may be asked to bring a claim form to your visit. Claim forms can be found at www.nedelta.com or you may call 800-832-5700.

**Remember: All Delta Dental PPO Dentists and Delta Dental Premier Participating Dentists agree to:**

- File your claim forms for you
- Charge you no more than the amount allowed for payment by Delta Dental
- Accept payment directly from Delta Dental

**4. How to File a Claim**

To Use Your Plan, Follow These Steps:

Please read this Appendix carefully to familiarize yourself with the benefits and provisions of your dental benefits program.

Ask your Dentist if he/she is a Delta Dental PPO Dentist or participates as a Delta Dental Premier Dentist; visit Delta Dental's website at **www.nedelta.com**, refer to the Delta Dental Participating Dentist Directory for a PPO Dentist, or call Delta Dental for information.

When you visit your dental office, inform them that you are covered under a Delta Dental program and provide your identification card or other means of verifying coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Delta Dental for payment for Covered Services. Clean written claims must be paid in 30 days; clean electronic claims must be paid within 15 days.

Participating Dentists: Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for Covered Services, but may request payment for non-covered services, and applicable Deductibles, Copayments and Coinsurance. Delta Dental will pay the Participating Dentists directly based on the allowed charges. An Explanation of Benefits will be sent or accessible to you which will indicate the amount you should pay, if any, to your Dentist.

Non-Participating Dentists or Other Dental Providers: Delta Dental provides benefits regardless of your choice of Dentist, participating or not. When visiting a Non-Participating Dentist or ODP (who is a person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered), you may be required to submit your own claim (available at **www.nedelta.com**) and pay for services at the time they are provided. All claims should be submitted to Delta Dental. Payment will be made directly to you. Some states may require that assignment of benefits (directing that payment be sent to the provider) be honored. In these instances, payment will be made directly to the Non-Participating Dentist or ODP when written notice of such an assignment is made on the claim. In either case, payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which services were provided. It is your responsibility to make full payment to the Dentist or ODP. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount.

You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

Prior Authorizations: For several identified procedures, Prior Authorization is required for Pediatric Members.

***Please note that Prior Authorization does NOT guarantee payment. A new coverage period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service) which may be different than information available at the time the Prior Authorization was given. Any changes in a Dentist's participating status or Delta Dental's allowance may also affect your plan's final payment.***

Predetermination of Benefits: Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding your plan's payment and your financial obligation to the Dentist. A Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office.

***Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of payment based on your current benefits. A new coverage period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service) which may be different than information available at the time the Predetermination estimate was given. Any changes in a Dentist's participating status or Delta Dental's allowance may also affect your plan's final payment.***

Questions concerning Prior Authorization and Predetermination should be directed to Delta Dental's Customer Service Department at 1-800-832-5700 or 603-223-1234.

**5. Benefits**

In this section of the Appendix, we give you the details of what services your dental benefits program covers and the conditions and limitations on those services. This section includes significant dental terminology adopted by the American Dental Association. We encourage you to discuss proposed services and treatment plans with your Dentist/dental office. In addition, should you have any questions regarding those services, you may call Customer Service at 1-800-832-5700 Monday through Friday from 8:00 a.m. to 4:45 p.m. EST excluding holidays.

**6. Coverage A - Diagnostic & Preventive Benefits**

**A. Diagnostic**

Oral evaluations are covered one time in a period of six (6) months. Evaluations can be comprehensive, limited or periodic and may be provided by a specialist or a general Dentist.

Limited oral evaluations.

Radiographic images are covered with limitations. Complete series or panoramic image once in a period of five (5) years. Bitewing images are covered once in a period of six (6) months. Images of individual teeth are covered as necessary.

Caries risk assessment is covered one time in a period of three (3) years for Pediatric Members ages three (3) and older.

**B. Preventive:**

Prophylaxis (cleaning) is covered one time in a period of six (6) months (child cleaning through age thirteen (13), adult cleaning thereafter). A cleaning can be routine under Diagnostic and Preventive Benefits or a periodontal maintenance under Basic Restorative Benefits.

A full mouth debridement is a covered benefit, once in a lifetime, under Diagnostic & Preventive Benefits. When performed, it is counted towards your prophylaxis (cleaning) benefit.

Fluoride treatments are covered two (2) times in a period of twelve (12) months.

Sealants are a covered benefit.

Space maintainers are a covered benefit.

**C. Palliative Treatment:**

Minor emergency treatment for the relief of pain.

***NOTE: Time limitations are measured from the date the services were most recently performed.***

***All Covered Services containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.***

**D. Diagnostic & Preventive Benefits - Exclusions and Limitations:**

- If the fee for a procedure or service is "**Disallowed**", it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**", it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient's plan.

1. Charges for oral evaluations of any kind are Disallowed, if performed within ninety (90) days after periodontal surgery, by the same Dentist/dental office.
2. Charges for oral evaluations for patients under age three (3) are Disallowed when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation.
2. Pre-diagnostic services, such as screening and assessment of a patient, are not covered benefits. Payment for a screening or assessment is Disallowed if billed with an oral evaluation.
3. A panoramic radiograph image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations. Any fee in excess of the fee for a complete series is Disallowed.
4. Unless there is evidence of trauma, charges for additional periapical and/or occlusal radiographic images within a thirty (30) days of a complete series or panoramic image is Disallowed.
5. Fees for additional radiographic images taken by the same Dentist/dental office within sixty (60) days of vertical bitewings are Disallowed.
6. When benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service.
7. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure. Separate fees are Disallowed on the same date of service.
8. The fee for a full mouth debridement is Disallowed when performed by the same Dentist/dental office on the same date of service as a comprehensive evaluation, detailed and extensive oral evaluation, or a comprehensive periodontal evaluation.
9. If the fee for bitewings, periapicals, intraoral occlusal and extraoral occlusal radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.
10. Cone beam imaging is not a covered benefit. Cone beam imaging, when performed by the same Dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined codes are Disallowed.
11. Cephalometric images, oral/facial photographic images, and diagnostic models are covered once every two (2) years when performed for potential Medically Necessary Orthodontic treatment only.
12. Oral cancer screening, except brush biopsy, is not a covered benefit.
13. Oral Pathology laboratory services are a covered benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same Dentist/dental office, payment is allowed for the most inclusive procedure and payment for the less inclusive procedure is Disallowed.
14. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures. The fee is Disallowed.
15. Cleanings (a Diagnostic & Preventive benefit) are included in both full mouth debridement (a Diagnostic & Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your cleaning benefit of once in a six (6) month period.
16. Laboratory tests for caries susceptibility are not a covered benefit. Fees are Disallowed when billed with an oral evaluation for children under the age of three (3).
17. Caries risk assessment is a covered benefit once in a period of three (3) years for Pediatric Enrollees age three (3) and older. Fees for caries risk assessment is Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.
18. The replacement of space maintainers is not a covered benefit. The patient is financially responsible.
19. The repair of space maintainers is not a covered benefit. The patient is financially responsible.
20. Recementation of a space maintainer is a covered benefit once in a lifetime per appliance.
21. Removal of a space maintainer is included as part of the total treatment. Charges for removal of a space maintainer are Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.
22. Distal shoe space maintainers are a covered benefit for Pediatric Enrollees age eight (8) and younger. Fees for distal shoe space maintainers performed on patients nine (9) and older are Denied.
23. Sealant benefits limitation:

i. The sealant benefit is for the application of sealants to caries-free and restoration-free, occlusal (biting) surface of permanent molars only.
ii. The sealant benefit is provided no more than once in a three (3) year period per tooth.
iii. Charges for sealants are Disallowed within two (2) years of initial placement on the same tooth by the same Dentist/dental office. Charges for a sealant is Disallowed if performed on the same tooth, by the same Dentist/dental office, on the same date of service as a restoration which includes the occlusal surface.

24. Preventive resin restorations are a covered benefit one (1) time per tooth in a period of three (3) years on permanent molars for Pediatric Enrollees only. Fees are Disallowed if replaced by the same Dentist/dental office within twenty-four (24) months. Fees for a preventive resin restoration are Disallowed if performed on the same tooth, by the same Dentist/dental office on the same date of service as another restoration.
25. The fee for preventive resin restoration is Disallowed if performed on the same date of service as a conventional restoration or palliative treatment by the same Dentist/dental office.
26. Pulp vitality tests are a covered benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment or a protective restoration. Payment is otherwise Disallowed.
27. Palliative treatment is a covered benefit. The third palliative treatment claim received in 180 days is subject to dental consultant's review.
28. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Disallowed.
29. The fee for palliative treatment is Disallowed when submitted with all procedures performed by the same Dentist/dental office on the same date, except radiographic images and diagnostic codes.
30. Viral culture tests, saliva tests, and oral cancer screening are not covered benefits. The patient is financially responsible.
31. Nutritional counseling, tobacco counseling, and oral hygiene instruction are not covered benefits. The patient is financially responsible.
32. TMJ related services are not covered benefits. The patient is financially responsible.

## 7. Coverage B - Basic Restorative Benefits

### A. Restorative:

Amalgam (silver) restorations (fillings) are a covered benefit.

Resin (white) restorations (fillings) on anterior teeth and the buccal surface of bicuspids only.

Prefabricated stainless steel crowns are a covered benefit.

Recementation of an inlay or crown is a covered benefit.

Protective restorations are a covered benefit.

### B. Periodontal Maintenance:

A periodontal maintenance procedure is a covered benefit after active periodontal therapy four (4) times in a twelve (12) month period, and when performed, is counted toward the prophylaxis benefit.

### C. Periodontics:

Periodontal scaling and root planing is a covered benefit once in a period of twenty-four (24) months.

### D. Endodontics:

Pulpotomy and pulpal therapy are covered benefits.

### E. Oral Surgery:

Extractions and certain surgical procedures are covered benefits.

### F. Prosthodontic Services:

Denture repair, adjustment, rebase and reline are covered benefits.

### G. Tissue conditioning:

Two (2) times in a three (3) year period.

### H. Anesthesia:

General anesthesia or intravenous sedation are covered benefits when done in conjunction with other covered services.

***Note: Time limitations are measured from the date the services were most recently performed.***

***All covered services containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.***

**I. Basic Restorative Benefits - Exclusions and Limitations:**

- If the fee for a procedure or service is "**Disallowed**", it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**", it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient's plan.

1. Resin (white) or amalgam (silver) restorations (fillings) are a covered benefit once per tooth surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. Charges for the replacement of silver or white fillings within twenty-four (24) months by the same Dentist/dental office is Disallowed.
2. Resin restorations in posterior teeth (white fillings in bicuspids and molars) are optional. If a resin restoration is performed on posterior teeth, other than the buccal surface of bicuspids, an allowance will be paid equal to an amalgam (silver) restoration, and the patient is responsible for any additional fee.
3. Resin based composite crowns on front teeth are a covered benefit once in a period of two (2) years per tooth for patients age twelve (12) and older. Fees are Disallowed if replaced within two (2) years by the same Dentist/dental office.
4. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Participating Dentist agrees not to charge a separate fee.
5. Prefabricated stainless steel crowns are a covered benefit once in a period of twenty-four (24) months. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement. A separate fee is Disallowed.
6. Prefabricated porcelain crowns are a covered benefit on primary teeth only, once in a period of twenty-four (24) months.
7. Recementation of a metallic inlay or onlay, or a crown or partial coverage restoration is a covered benefit once in a lifetime. Payment for recementation of an inlay or onlay, crown or partial coverage restoration is Disallowed when performed within six (6) months of the initial placement by the same Dentist/dental office.
8. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Participating Dentist agrees not to charge a separate fee.
9. Fees for protective restorations are Disallowed if performed on the same date of service as a palliative treatment by the same Dentist/dental office.
10. A Routine cleaning is included in a full mouth debridement and a periodontal maintenance cleaning. As a result, each of these procedures is counted toward your cleaning benefit of once in a six (6) month period.
11. A clearning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures. The fee is Disallowed.
12. Fees for periodontal maintenance are Disallowed when billed within three (3) months of periodontal therapy by the same Dentist/dental office.
13. Periodontal scaling and root planing is a covered benefit per quadrant once in a period of twenty-four (24) months. Benefits are paid for a maximum of two (2) quadrants per office visit. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. If treatment is done by a different Dentist within twenty-four (24) months, benefits are Denied. The patient is responsible for the fee.
14. A partial pulpotomy is a covered benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within forty-five (45) days on the same tooth by the same Dentist/dental office as root canal therapy.
15. Pulpal therapy is a covered benefit once in a three (3) year period on primary first and second molars only. If pulpal therapy is performed on primary anterior or permanent teeth, the procedure will be covered as a palliative treatment.
16. Therapeutic pulpotomy is a covered benefit once in a three (3) year period per tooth on primary teeth only. If the service is provided on permanent teeth, the procedure will be covered as palliative treatment.

17. Pulpal debridement is a covered benefit once in a lifetime. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office.
18. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.
19. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Fees for additional pins in the same tooth are Disallowed. The fee for pin retention is Disallowed when billed in conjunction with a core buildup.
20. Post-operative treatment of complications from oral surgery is a covered benefit once per surgical site, subject to a dental consultant's review. The fee for post-operative treatment of complications is Disallowed if performed within thirty (30) days by the same Dentist/dental office as the oral surgery.
21. The fee for removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.
22. Alveoplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office in the same surgical area on the same date.
23. A frenulectomy or frenuloplasty is a covered benefit once per site per lifetime. The fee is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.
24. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.
25. An internal root repair is a covered benefit once in a lifetime on permanent teeth only. If performed on a primary tooth the benefit is Denied. The fee for an internal root repair is Disallowed if performed on the same date of service by the same Dentist/dental office as a apicoectomy or retrograde filling.
26. A consultation performed by a Dentist who is not performing further services is a covered benefit. The fee for a consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.
27. Exploratory surgical services are not a covered benefit. The patient is financially responsible.
28. General anesthesia is a covered benefit only when administered by a properly licensed Dentist in a dental office with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.
29. The fee for repairs of complete or partial dentures cannot exceed half the fee for a new appliance. Any excess fee billed by the same Dentist/dental office on the same date of service is Disallowed.
30. Fees for adjustments or repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office, are Disallowed.
31. Adjustment or repair of a denture is a covered benefit twice in a twelve (12) month period. Fees for an adjustment of repair of a denture are Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance. Any excess fee by the same Dentist/dental office on the same date of service is Disallowed.
32. The relining of a denture is a covered benefit two (2) times in a period of twelve (12) months. The fee for reline of a denture cannot exceed one-half of the fees for a new appliance. Any excess fee by the same Dentist/dental office on the same date of service is Disallowed.
33. The rebase of a denture is a covered benefit once in three (3) years. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance. Any excess fee by the same Dentist/dental office on the same date of service is Disallowed.
34. The fee for a reline or rebase of a denture is Disallowed if performed within six (6) months of initial placement by the same Dentist/dental office.
35. Rebase and reline include adjustments required within six (6) months of delivery. When an adjustment is billed within six (6) months of a rebase or reline by the same Dentist/dental office, fees for the adjustment are Disallowed.
36. Recementation of a fixed partial denture is a covered benefit once in a period of twelve (12) months. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same Dentist/dental office.
37. Cleaning and inspection of a removable complete or partial denture is not a covered benefit. The fee for cleaning and inspection of a removable complete or partial denture is Disallowed when done by the same Dentist/dental office on the same date of service as a reline or rebase of the denture. Otherwise, the fee for cleaning and inspection of a removable complete or partial denture is Denied.
38. Bone replacement graft for ridge preservation is a covered benefit, once per site per lifetime.

39. Recementation of a prefabricated post and core is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.
40. Tissue conditioning is a covered benefit two (2) times in a three (3) year period. The fee for tissue conditioning is not a benefit if performed on the same day the denture is delivered or a reline/rebase is provided by the same Dentist/dental office and is Disallowed.
41. Tooth preparation, bases, copings, protective restorations, impressions, and local anesthesia, or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure. Separate fees are Disallowed.
42. Therapeutic drug injections are a covered benefit subject to a dental consultant's review.
43. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure. Separate fees are Disallowed.
44. Excision of lesions is not a covered benefit. The patient is financially responsible.
45. Interim caries arresting medicament application is not a covered benefit.

***Please note:*** ***Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

**8. Coverage C - Major Restorative Benefits**

**A. Restorative Crowns and Onlays:**

Crowns and metallic inlays and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.

Core build-ups, prefabricated post and cores, and crown, inlay, onlay, and veneer repairs for enrollees age twelve (12) and older.

**B. Endodontics:**

Root canal therapy, apicoectomy, apexification, root amputation, and hemisection.

**C. Periodontics:**

Gingivectomy, gingivoplasty, gingival flap procedure, clinical crown lengthening, osseous surgery, and soft tissue graft.

**D. Prosthodontics:**

Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures.

**E. Implant Services:**

Surgical placement of an implant body, including healing cap, for enrollees age sixteen (16) and older.

**F. Implant Supported Prostheses:**

Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device for enrollees age sixteen (16) and older.

**G. Occlusal Guard:**

Once in a twelve (12) month period for patients age thirteen (13) and older.

***Note:*** ***Time limitations are measured from the date the services were most recently performed.***

***All covered services containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.***

**H. Major Restorative Benefits - Exclusions and Limitations:**

- If the fee for a procedure or service is "**Disallowed**", it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**", it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient's plan.

1. Inlays and onlays (metallic) and crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Enrollees under the age of twelve (12) without a Prior Authorization.
2. Time limitations:
    i. One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in a period of five (5) years.
    ii. One (1) immediate maxillary (upper) and one (1) immediate mandibular (lower) denture in a period of five (5) years.
    iii. A removable or fixed partial denture in a period of five (5) years unless the loss of additional teeth requires the construction of a new appliance.
    iv. Metallic onlays, crowns, core buildups, and post and cores are a benefit once per tooth in a period of five (5) years.
3. A core buildup is a covered benefit once in a five (5) year period per tooth for patients age twelve (12) and older. The fees for core buildups are Disallowed when performed in conjunction with inlays, ¾ crowns or onlays and indirectly fabricated or prefabricated post and cores.
4. A provisional crown or a provisional implant crown is considered part of a crown procedure when performed by the same Dentist/dental office as a permanent crown. A separate fee is Disallowed.
5. An indirectly fabricated or prefabricated post and core is payable only on an endodontically treated tooth and is a covered benefit once in a five (5) year period for patients age twelve (12) and older. Fees for post and cores are Disallowed when radiographic images indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth. Each additional post in the same tooth is considered part of the post and core procedure. A separate fee is Disallowed.
6. A core buildup or indirectly fabricated or prefabricated post and cores in conjunction with a affixed partial denture crown are a covered benefit once in a seven (7) year period per tooth for Eligible Persons age sixteen (16) and older.
7. Scaling and debridement in the presence of inflammation or mucositis of a single implant is a covered benefit once in a twenty-four (24) month period. Fees for retreatment are Disallowed if performed within twelve (12) months of restoration or within twenty-four (24) months of initial therapy by the same Dentist/dental office. If performed by a different Dentist/dental office, the fee is Denied.
8. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Disallowed when performed in the same quadrant by the same Dentist/dental office a periodontal scaling and root planing or gingival flap procedure, and osseous surgery or debridement of peri-implant defect.
9. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Disallowed when performed in conjunction with a cleaning, periodontal maintenance or scaling of moderate or severe gingival inflammation.
10. Removal of coronal remnants of a primary tooth is considered part of any other (more comprehensive) surgical procedure in the same surgical area, same date by the same Dentist/dental office, and the fees are Disallowed.
11. Root canal therapy is a covered benefit once per tooth in a period of twenty-four (24) months. Retreatment of root canal therapy or retreatment of apical surgery by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.
12. Anterior deciduous root canal therapy is not a covered benefit.
13. Root canal therapy is not a benefit in conjunction with overdentures. Benefits are Denied.
14. Post removal is Disallowed if performed within thirty (30) days of an endodontic treatment and by the same Dentist/dental office performing the endodontic treatment.
15. Direct or indirect pulp caps are a covered benefit once per tooth in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure. The fee for the pulp cap is Disallowed.
16. The fee is Disallowed for root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office.
17. Incomplete endodontic procedure due to inoperable or fractured tooth may be covered at 50% of the fee for a completed endodontic therapy, subject to a consultant’s review of radiographic images and clinical notes.
18. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, and evaluations for three (3) months, as well as any surgical re-entry (except soft tissue grafts), for three (3) years. When a

surgical procedure is billed within three (3) months of the initial surgical procedure by the same Dentist/dental office, the fee for the surgery is Disallowed.

19. Gingivectomy, gingivoplasty, gingival flap procedure, bone replacement graft in conjunction with flap surgery, mesial/distal wedge, connective tissue graft or soft tissue graft procedure are covered benefits once in a period of three (3) years on natural teeth. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.
20. Osseous surgery is a covered benefit per quadrant (maximum of two (2) quadrants per office visit) once in a period of three (3) years. Fees are Disallowed for surgical re-entry by the same Dentist/dental office within a three (3) year period, and/if more than two (2) quadrants are treated in one office visit.
21. An apexification or an apicoectomy is a covered benefit once per tooth in a period of three (3) years. The fee for retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.
22. Retrograde fillings are a covered benefit once per root per three (3) years. The fee for retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.
23. The fee is Disallowed for periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation.
24. Clinical crown lengthening is a covered benefit once per tooth in a three (3) year period and only when performed in a healthy periodontal environment, on natural teeth only, in which bone must be removed for placement of the restoration or crown, or prosthetic device. The fee for clinical crown lengthening is Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.
25. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.
26. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a dental consultant's review. Payment will be based on the most comprehensive procedure.
27. An interim complete denture is not a covered benefit. Fees are Disallowed if billed in conjunction with a permanent appliance.
28. An interim partial denture is a covered benefit for Eligible Dependents through age sixteen (16) on anterior, permanent teeth only. The fee for an interim partial denture is Disallowed if billed in conjunction with a permanent appliance on the same day by the same Dentist/dental office.
29. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are a covered benefit. The patient will be responsible for any additional fee.
30. The fee for sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Disallowed. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a dental consultant.
31. An implant body, including healing cap, is a benefit once in a five (5) year period for enrollees age sixteen (16) and older.
32. Implant services and implant support prosthetics are not a covered benefit for patients under the age of sixteen (16).
33. Removal of an implant is a covered benefit once in a five (5) year period per tooth per site.

***Please note: Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental encourages Predetermination of cases involving costly or extensive treatment plans. Although not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

**9. Coverage D - Orthodontic Benefits**

**A. Medically Necessary Orthodontia:**

Medically Necessary Orthodontic treatment and procedures used for the correction of malposed (crooked) teeth, including the placement of a device to facilitate eruption of an impacted tooth. Medically Necessary Orthodontic treatment and procedures are subject to Prior Authorization)

**B. Medically Necessary Orthodontic Benefits - Exclusions and Limitations:**

- If the fee for a procedure or service is "**Disallowed**", it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**", it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient's plan.

1. For Medically Necessary Orthodontic treatment commenced while a Pediatric Enrollee is eligible for orthodontic benefits under this policy, Delta Dental will initiate payment of its liability once bands or orthodontic devices are placed. Delta Dental requires a dental consultant's review to determine if orthodontic treatment is medically necessary.
2. For Medically Necessary Orthodontic treatment commenced prior to becoming eligible under this policy, Delta Dental will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment. Delta Dental requires dental consultant review to determine if orthodontic treatment was medically necessary at the start of treatment.
3. Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.
4. Delta Dental will make one (1) payment of twenty-five percent (25%) of the allowed charge at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of thirty-six (36) months for its total liability. "Start of treatment" means the date of initial banding or a segment thereof, or a device is placed in the patient's mouth. Periodic monthly payments will continue based upon the continuing eligibility of the Pediatric Enrollee.
5. Cephalometric images, oral/facial photographic images and diagnostic models are a covered benefit with Medically Necessary Orthodontic treatment only.
6. The replacement of an orthodontic appliance is a covered benefit once per arch in a lifetime.
7. The repair of an orthodontic appliance is not a covered benefit. The patient is financially responsible.
8. Rebonding or recementation of a fixed retainer is a covered benefit once in a lifetime per patient if performed by a different Dentist than the Dentist who placed the appliance. Rebonding or recementation of a fixed retainer by the same Dentist/dental office who placed the original device is Disallowed.
9. Repair of a fixed retainer (including reattachment) is a covered benefit once in a lifetime per patient if performed by a different Dentist/dental office than the one who placed the appliance. Repair of a fixed retainer by the same Dentist/dental office who placed the original device is Disallowed.
10. Occlusal orthotic device adjustments are not a covered benefit.

***Please note: Certain procedures for Pediatric Members as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

## 10. General Exclusions and Limitations

1. **The dental benefits provided by Delta Dental shall not include the following services:**
   a. Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability Laws are not a covered benefit.
   b. Services that are determined by Delta Dental to be provided for cosmetic reasons are not a covered benefit. This includes bleaching or whitening of teeth (unless discolored by previous endodontic therapy), placement of veneers, correction of congenital malformations, or cosmetic surgery. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.
   c. Services completed when Enrollees were not covered under the policy are not a covered benefit. Such services include, but are not limited to, endodontics and prosthodontics (including restorative crowns and onlays).
   d. Services not provided by a Dentist, an independent practice dental hygienist, a dental hygiene therapist, or under the supervision of a Dentist, or not within the scope of the license of the Dentist, the independent

practice dental hygienist, the dental hygiene therapist, or the person supervised by the Dentist are not a covered benefit, unless otherwise required by law.

e. Charges for prescription drugs or the application of anti-microbial agents are not a covered benefit.
f. Charges for: (i) hospitalization; (ii) preventive control programs; (iii) myofunctional therapy; (iv) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (v) equilibration; and (vi) gnathological reporting are not a covered benefit.
g. Charges for failure to keep a scheduled visit with the Dentist are not a covered benefit.
h. Charges for completion of forms are not a covered benefit. Such charges shall not be made to an Enrollee by Participating Dentists.
i. Dental Care which is not necessary and customary, as determined by generally accepted standards of dental practice are not a covered benefit.
j. Dental Care or supplies not within the benefits for the option selected are not a covered benefit.
k. Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, or restoring occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) correcting congenital or developmental malformations; or (v) esthetic purposes are not a covered benefit. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.
l. Payments of benefits incurred by you or the Enrollee after the date on which the Enrollee becomes ineligible for benefits are not a covered benefit.
m. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits are not a covered benefit.
n. Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared are not a covered benefit.
o. Temporary services are not a covered benefit.
p. A treatment that is incomplete is not a covered benefit.
q. A consultation is not a covered benefit, unless being done by someone who is not performing further services.
r. Consultation with medical health care professional and dental case management for addressing appointment compliance barriers and care coordination are part of the overall patient management and the fees are Disallowed. Dental case management for motivational interviewing and patient education are not a covered benefit. If services are provided on the same day by the same Dentist/dental office as nutritional or tobacco counseling or oral hygiene instruction, fees for dental case management for motivational interviewing and patient education are Disallowed.
s. Case presentation and treatment planning are not a covered benefit. You or the Enrollee will be responsible for any additional fee.
t. Athletic mouthguards are not a covered benefit.
u. The fees for transmitting data via teledentistry are considered inclusive in the overall dental procedure(s) being performed and separate fees are Disallowed.

**C. The dental benefits provided by Delta Dental shall be limited as follows unless otherwise required by Maine law:**

a. Dental Care rendered by anyone other than a Dentist shall not be a benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as either:
    i. The treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted standards of dental practice.
    ii. The treatment is provided by an independent practice dental hygienist within the lawful scope of practice of that independent practice dental hygienist.
    iii. The treatment is provided by a dental hygiene therapist within the lawful scope of practice of that independent practice dental hygiene therapist.
b. Optional Dental Care: In all cases in which you and/or the Enrollee, after consultation with your Dentist, agree to more expensive Dental Care than customary, Delta Dental will pay the Coinsurance Percentage for the Dental Care which is usually given to fix the tooth to contour and function. You and/or the Enrollee shall pay the remainder of the Dentist’s fee.

c. Predetermination and Prior Authorization do not guarantee payment. Payment is based upon eligibility, benefits selected, and allowable charges at the time the Dental Care is provided. If Coordination of Benefits is involved, the amount of payment is subject to change based on the payment made by the primary carrier.
d. Services completed at the Enrollee's date of death will be paid in full to the limit of Delta Dental's liability.
e. When services for Dental Care in progress are interrupted and completed at a later date by another Dentist, Delta Dental will review the claim to decide what payment, if any, is due to each Dentist.
f. Specialized techniques such as precision attachments, overdentures and associated procedures, and personalizations or characterization are excluded. You and/or the Enrollee will need to pay for part of or the entire fee for these services.
g. Interpreter services are a covered benefit when they are done at the same time as other covered services. Interpreter services are a covered benefit for Pediatric Enrollees only.
h. Delta Dental programs provide amalgam (silver) and resin (white) restorations (fillings) for treatment of caries. If a white filling is performed, an allowance of the cost of a silver filling will be paid towards the cost of the white filling and the patient will be responsible for the payment of the balance. If the teeth can be restored with such materials, any gold restorations, or crowns are also considered optional. You and/or the Enrollee will need to pay for any additional fee.
i. Notice of sickness or of injury must be given to Delta Dental within twenty (20) days after the date when such sickness or injury occurred or as soon as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.
j. Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this policy with the time fixed in the polilcy for filing claims. Notice given by or on behalf of you to Delta Dental, or to any authorized agent of Delta Dental, with information sufficient to identify you, shall be deemed notice to your Delta Dental.
k. A completed claim must be furnished to Delta Dental within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) months.
l. The Date of Incurred Liability is the date a service is subject to the Deductible, Copayment, Coinsurance Percentage, and limitations. Except as otherwise noted, the total cost of the service is applied to the Plan Year during which the service is completed, regardless of the Plan Year in which the service is started.

   For services covered, Delta Dental's payment for multiple visit procedures is based on the following dates:

   i. Crowns: The total cost for crowns is based on the date that the crown is cemented. Pediatric Enrollees under the age of twelve (12) need a Prior Authorization.
   ii. Fixed Partial Dentures: The total cost for fixed partial dentures is based on the date that the dentures are cemented.
   iii. Removable Complete and Partial Dentures: The total cost for removable complete and partial dentures is based on the date that the dentures are given to the patient.
   iv. Endodontics (root canal): The total cost for a root canal is based on when the tooth canal is filled to completion.
   v. Implant for Enrollees age sixteen (16) and older: The total cost for implants is based on the date the implant was surgically placed.
   vi. Implant Prosthetics for Enrollees age sixteen (16) and older: The total cost for the implant prosthetic is based on the date that the prosthetic is cemented or delivered to the patient.

**2. Claims Review and Appeal**

**A. General Claims Inquiry:**

After a claim is submitted by your Dentist and processed by Delta Dental, you and/or the Pediatric Member will have access to an Explanation of Benefits. This notice will explain the benefits that were paid on your behalf, let you know if any services are Denied or Disallowed, and give you the reason(s) for the denial or disallowance.

If you have any questions regarding your benefits, you may call Delta Dental for an explanation at 603-223-1234. The toll-free number is 1-800-832-5700. You will be connected directly to our Customer Service Department.

The Customer Service Representative will need to know the claim number that is located on your Explanation of Benefits or, if that information is not available, the Subscriber's identification number and date of treatment. This will enable a quick response to your inquiry.

**B. Disputed Claims Procedure:**

If you have reason to believe your benefit determination was not in accordance with the terms of your plan, you have the option of using Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the date of Northeast Delta Dental's original Explanation of Benefits. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to Director, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002, but you may also submit your request by standard mail.

Your request for a review of your claim should refer to the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated. You may provide any additional materials you wish to present.

The Director, Professional Relations, or his/her designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is Denied in any respect, you will be furnished with a written notice of the decision within thirty (30) days after receipt of the disputed claim. The written notice will include:

i. the specific reason(s) for denial, and
ii. the specific reference to the provision of this Agreement upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the response from the Director, Professional Relations, or his/her designee.

If you have not received a written response within the thirty (30) day period, and/or disagree with the response you received, you may proceed to the Disputed Claims Review Procedure in Section C below.

If you have any problem securing a review of your claim, you may also contact:

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

OR

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)

Fax: 207-624-8599

http://www.state.me.us/pfr/insurance/index/shtml

**C. Disputed Claims Review Procedure**

After you have followed the Disputed Claims Procedure in Section B, and you still believe your benefit determination was not in accordance with the Agreement, you have the option of using Northeast Delta Dental's Disputed Claims Review Procedure. This procedure allows you to request a review by the Review Committee regarding the continued denial of your claim. The Review Committee is composed of Participating Dentists, non-dentist members of the Board of Directors, and representatives of purchasers.

You or your duly authorized representative may Appeal to the Review Committee by filing a request for review within one hundred eighty (180) days after denial of your claim following the Disputed Claims Procedure. It is recommended that your written request should be sent certified mail, return receipt requested, to the Review Committee at the Delta Dental address noted previously, but you may also submit your request by standard mail. It must state with specificity the reasons for requesting a review. It should contain the issues, comments, and supporting materials stating why you believe the response of the Northeast Delta Dental Director, Professional Relations or his/her designee was incorrect.

A decision will be provided within thirty (30) days after receipt of your request. The decision of the Review Committee will be in writing and include specific reasons for the decision.

In addition, or as an alternative to the written request procedure, you may request a hearing from the Review Committee to consider matters raised in your Appeal. At the hearing, you are entitled to representation by a lawyer or other representative, to request a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the policy and related pertinent documents. The hearing will be scheduled with prompt written notice to you no later than thirty (30) days after your request. A decision will be provided no later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

**D. Notice of Right to Appeal Your Health Insurer's Final Decision**

You may have a legal right to have our decision reviewed by an organization that is neutral. This is called Independent External Review.

**You must ask for this Independent External Review no later than one year after receiving the notice of internal review denial.**

Call the Department of Professional & Financial Regulation at 800 300-5000 to ask for this review.

Department of Professional & Financial Regulation
Bureau of Insurance
#34 State House Station Augusta, ME 04333-0034
800-300-5000 (toll free in Maine) or 207-624-8475

**3. General Conditions**

**A. Transfer of Benefits Prohibited:**

Benefits of Pediatric Members are personal and cannot be transferred.

**B. Right of Recovery:**

Delta Dental will succeed to the Enrollee's right of recovery against any third person or organization that may be liable.

**C. Physical Examinations:**

In consideration of waiving physical examination of you or your Dependent(s) and as a condition precedent to the approval of claims, Delta Dental shall be entitled to receive from any attending or examining Dentist or from hospitals in which a Dentist's service is rendered, such information and records relating to attendance of, or examination of, or treatment rendered to such person as may be required in the administration of such claim to such extent as may be lawful. Delta Dental is responsible for such information and records. At its own expense, Delta Dental shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim for the insured is pending. However, Delta Dental shall, in every case, preserve the privacy of such information except as is necessary for the proper administration of Delta Dental plans.

**D. Doctor-Patient Relationship:**

The Pediatric Member has the freedom to choose any Dentist or ODP. Dentists and ODPs rendering service under this dental benefits program are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist or ODP will be solely responsible to the patient for dental advice and treatment and any resulting liability.

**E. Loss of Eligibility during Treatment:**

If Pediatric Member loses eligibility while receiving dental treatment, only Covered Services received while eligible will be considered for payment. Someone enrolled under your policy may lose eligibility if such person ceases to be an eligible person in accordance with the provisions of the Agreement and the policies of HHS.

**F. Maintaining Your Privacy:**

Delta Dental has always respected and carefully preserved the privacy and confidentiality of Subscribers, Members, and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

By receiving coverage pursuant to this dental plan, each Pediatric Enrollee, including a parent or guardian in the case of a minor Dependent, agrees that, except as restricted by applicable state and federal laws, Northeast Delta Dental may have access to all dental and health records, and medical data from Dentists, ODPs, and other health care providers for reasons of essential insurance functions; claims administration; claims adjustment and the management, detection, investigation, or reporting of actual or potential fraud; misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; or quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit.

For a copy of Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800- 537-1715

**G. Entire Agreement; Modification:**

The Certificate of Insurance, together with the Contract Application, constitutes the entire contract of insurance. The provisions of this Appendix and the Certificate of Insurance are subject to the Maine Bureau and FFM requirements and modifications. Additionally, we reserve the right to implement changes in American Dental Association (ADA) dental terminology and CDT codes and Delta Dental internal processing policies which do not materially affect the provisions of this Appendix. Any material change shall be valid only if approved by the Maine Bureau and an executive officer of Delta Dental and Health Options. Any material change evidenced by a written, signed amendment hereof or endorsement hereto. Any such amendment or endorsement will be provided to you at least sixty (60) days in advance of its effective date. No broker or agent has authority to change this Certificate of Insurance or waive any of its provisions.

## 4. Glossary

1. Agreement: The Member Benefit Agreement between Health Options and the Member, including all schedules, riders, applications and appendices attached thereto.
2. DDPA (Delta Dental Plans Association): the association which comprises all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
3. Denied: if the fee for a procedure or service is Denied and chargeable to the patient, the procedure or service is not a benefit of the patient's plan. The approved amount is not payable by your plan, but is collectable from the patient.
4. Dental Care: services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practices at the time the service is rendered.
5. Dentist: a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
6. Disallowed: if the fee for a procedure or service is Disallowed, it is not payable by your plan, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section 6 identify services which are Disallowed. In each instance, a Delta Dental Participating Dentist agrees not to charge a separate fee.
7. Medically Necessary Orthodontia: "Medically Necessary Orthodontic Services" means orthodontic services to help correct severe handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth. Examples of conditions causing such deformities include, but are not limited to, cleft palate, Treacher-Collins

syndrome, Pierre-Robin syndrome, Marfan syndrome and Crouzon syndrome. Such conditions often require a combined pre- or post-orthognathic surgery/orthodontic treatment approach.

8. Non-Participating Dentist: a Dentist who has not signed a Participating Agreement with Delta Dental Plan of Maine or another Delta Dental company.
9. Other Dental Providers (ODP): A person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered.
10. Participating Dentist: a Dentist who has signed a Delta Dental Participating Agreement. A Dentist who has signed a Participating Agreement with a Delta Dental company in another state is also considered a Participating Dentist.
11. Pediatric Member: the Subscriber if under the age of nineteen (19) on the effective date of your plan, and any enrolled Dependent under the age of nineteen (19) on the effective date of your plan.
12. Plan Year: the time period commencing with enrollment through the end of the calendar year.
13. Predetermination: an administrative procedure by which the Dentist submits the treatment plan to Delta Dental in advance of performing Dental Care. Delta Dental recommends that you ask your Dentist to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what Delta Dental will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist.
14. Prior Authorization: a required administrative procedure by which the Dentist submits a proposed treatment plan to Delta Dental in advance of performing certain specified procedures of Dental Care for approval based upon standardized and valid risk assessment tools or a Delta Dental dental consultant's review.
15. Processing Policies: policies approved by Delta Dental, as may be amended from time to time, to be used in processing claims for payment or review, and processing treatment plans for Prior Authorization or Predetermination. Most frequently used Processing Policies are contained in the terms, conditions, exclusions, and limitations described in this Appendix.

Northeast Delta Dental
Delta Dental Plan of New Hampshire, Inc.
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
www.nedelta.com

*Customer Service*
603-223-1234
1-800-832-5700
TTY/Hearing Impaired
1-800-332-5905

*Corporate Office*
603-223-1000
1-800-537-1715
Fax: 1-800-223-1199