Taro Health

Direct Primary Care Silver AIAN LCS

Evidence of Coverage
January 1 - December 31, 2024

THIS CERTIFICATE IS ALSO AVAILABLE AS A CHILD ONLY POLICY

This Certificate is Guaranteed Renewable subject 24-A M.R.S.A. § 2850-B.

Hello! We're Taro Health

We're Taro Health Plan of Maine, Inc., which we will refer to as "Taro" or "Taro Health" throughout this document. We are a health insurance company that believes great care starts with your relationship with your doctor, and that health insurance shouldn't get in the way. We are proud to offer you the type of insurance that we personally wanted to exist for ourselves and our families.

We created health insurance plans that you can actually use, with great benefits like primary care with no Member Cost-Share, starting immediately. That means you can receive holistic and personalized care from your Primary Care Physician (PCP) with no Copays, Coinsurance, or additional fees for all of your core needs. You can meet with and select a PCP to become your personal dedicated provider, who will make the time to develop a relationship with you, understand your unique needs and goals, and design a personal path for your healthcare—all without worrying about your Deductible, Copays, or Coinsurance. Just you and your doctor: we want you to use your PCP early and often, which will help ensure that you stay healthy and in control of your health.

If you are an existing Direct Primary Care (DPC) patient, you already know this isn't too good to be true, and you'll continue to receive the access and attention you've come to love and expect. If you're new, you can learn more about what makes us special at tarohealth.com.

If and when You need health care services beyond primary care, we're proud to cover You with a comprehensive and high quality network. This document will help You understand exactly what is covered, how to get access to these services, and more. But if You ever need anything, please don't hesitate to reach out by calling Us at 1-833-928-0569.

Thank you so much for choosing Taro Health! It is truly our privilege and honor to serve You.

Frank Wu
CEO and Co-founder, Taro Health

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Introduction

You are Enrolled in Taro Health Direct Primary Care Silver AIAN LCS

You are receiving individual major medical expense coverage for Your health insurance.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Affordable Care Act (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About This Evidence of Coverage Document

The Evidence of Coverage defines the relationship between Taro Health and You, Our Member. The EOC gives You the details about Your health insurance coverage, and describes Your benefits, exclusions, conditions and other important information. In short, it explains how to get coverage for the health care services and prescription drugs You need. **This is an important legal document. Please read it carefully and keep it in a safe place.**

For additional plan documents, such as reimbursement forms, please visit https://www.tarohealth.com/maine/members/resources.

How to Contact Us

For assistance with claims, billing, or ID Card questions, please call or write to Taro Health Member Services.

Method	Contact information
Call Us by telephone	1-833-928-0569 All calls to this number are free. The Member Services telephone number is also printed on the Member's Identification Card. **Hours of operation** Monday - Friday

	8:00 AM to 6:00 PM EST
Write to Our office	Taro Health Plan of Maine PO Box 10110 Austin, TX 78766
Visit Us online	www.tarohealth.com

After Hours Care

If You need After Hours Care for medical care after normal business hours, Your DPC may have several options for You. You should call Your DPC's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

Important Notice About Your Provider Network and Benefits

This is a traditional HMO network Plan. You have access to both the "Taro Health Maine MP Network" and the "Taro Health Maine DPC Network".

Your Network includes providers throughout the states of Maine and New Hampshire only. There are however some limited instances where services performed outside the states of Maine and New Hampshire are covered under Taro.

Coverage outside the states of Maine and New Hampshire is limited only to the following services:

- Emergencies services, including the facility, physicians or other providers you see as part of your Emergency visit;
- services provided on a non-emergency basis at a Network facility by a Non-Network emergency Physician, assistant surgeon, surgical assistant, laboratory technician, radiologist, anesthesiologist, pathologist, or consulting Physician;
- Urgent Care services;
- Network Laboratory services; and
- Network Durable medical equipment.

If you receive services from providers or facilities outside the states of Maine or New Hampshire other than those listed above, they will not be covered by Taro Health and you will be responsible for their full cost.

It's important to confirm that a provider is in Taro's Network first before seeking services. Please refer to the online provider directory available at tarohealth.com to determine if a particular provider is in the network, or contact Member Services for assistance.

It is critical that You check if a provider or Facility is in Network before seeking services. You will be financially responsible for the full cost of services if You use a Non-Network Provider.

Note: Prior Authorization from Taro Health is needed to see a Non-Network Provider unless it's an Emergency or urgent care visit. Coverage is provided for Emergency Services and urgent care, even if obtained with a Non-Network Provider. We do not cover non-emergency care outside the states of Maine or New Hampshire.

Emergency Out of Area Care

If You have an Emergency while You are out of the states of Maine or New Hampshire, call 911 or go to the nearest Emergency Room.

How to Obtain Language Assistance

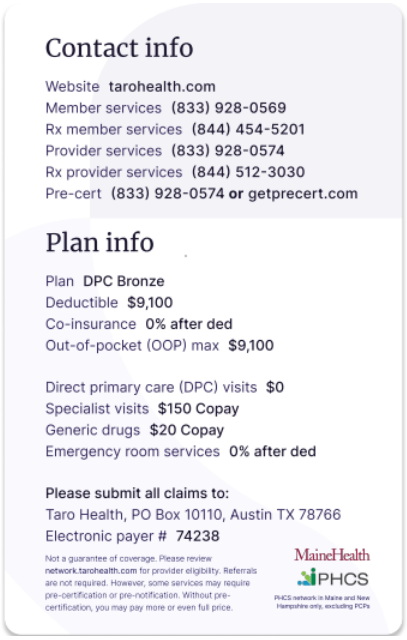
Taro Health is committed to communicating with Our members about their health plan, no matter what their language is. Taro Health employs a language line interpretation service for use by all of Our Member Services call centers. Simply call the Member Services phone number and a representative will be able to help You. Translation of written materials about Your benefits can also be asked for by contacting Member Services. Teletypewriter / Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

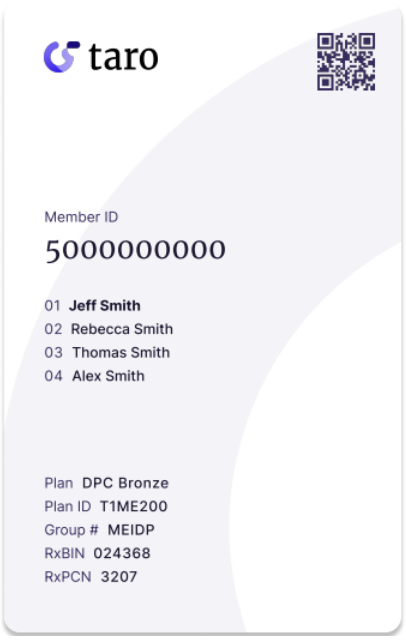
Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the Member Services number.)

Your Membership Identification Card (ID Card)

While You are a member of Our plan, present Your ID Card for Our plan whenever You get any services covered by this plan and for prescription drugs You get at Network Pharmacies. Here's a sample ID Card to show You what Yours will look like:





It's Important We Treat You Fairly

That's why We follow federal and state civil rights laws in Our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, sex, gender, gender identity, genetic information, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health status, disability, sexual preference or orientation, or veteran's status.

For people with disabilities, We offer free aids and services. For people whose primary language isn't English, We offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your ID card for help (TTY/TDD: 711).

If You think We failed to offer these services or discriminated basis of race, sex, gender, gender identity, genetic information, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health status, disability, sexual preference or orientation, or veteran's status, You can file a complaint, also known as a grievance. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

How Your Plan Works

Out-of-Pocket Costs

Deductible

Our plans provide a number of benefits before You reach Your annual Deductible, including Direct Primary Care with no Member Cost-Share, and can be found on Your Schedule of Benefits.

For other care, except where stated otherwise, You must pay the yearly Deductible amount on Your Schedule of Benefits for Covered Services during each Plan Year before We provide coverage. Expenses for Non-Covered Services will not apply to the Deductible. Copayments and Coinsurance amounts do not apply to the Deductible.

If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

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 Taro Health, if any.

Depending on the services provided in a single appointment it is possible You may be financially responsible for two Copays for one date of service or one Copay with an additional amount applied to Your Deductible/Coinsurance.

Out-of-Pocket Limit

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 Limit. Please see the Schedule of Benefits for details on Your Out-of-Pocket Limit and any Covered Services that do not apply to the Out-of-Pocket Limit. 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.

Family Out-of-Pocket Limit

Under family coverage, once the full Family Out-of-Pocket Limit 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 Limit. Once the Family Out-of-Pocket Limit 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.

Your Primary Care is Provided by a “Direct Primary Care” Physician

Primary care in the Taro Health network is rendered by Direct Primary Care (DPC) physicians. They are different from traditional primary care doctors in that DPCs cap the total number of people they see in a year to allow them to have more time and flexibility for their patients, like You. This allows them to provide more attention and care during unrushed visits, which ultimately helps build a more trusted patient-physician relationship. Once You find a DPC that best fits You and Your needs, You will see the same physician consistently, whether it is in-person, over video (Telemedicine), or other modes of communication like phone calls, email, or even text. There is no Member Cost-Share for your DPC visits themselves, but services provided to you by a DPC in addition to the visit, such as labs, prescription medications, and procedures may apply cost sharing. See your plan's Schedule of Benefits for more information on the specific benefits that apply.

You can only see one DPC at a time. Please be aware that under your DPC plan, primary care must be provided by a Direct Primary Care Physician, with the exception of OB/GYN services for women and pediatricians for children. Primary care services performed by primary care providers that are not DPCs, such as services from family medicine providers, will not be covered under your plan even if the provider is in Taro's network.

Your Direct Primary Care Comes with No Member Cost-Share

Taro Health offers access to Your selected Direct Primary Care Physician (DPC) There is no Member Cost-Share for your DPC visits themselves (even before You reach Your Deductible), but services provided to you by a DPC in addition to the visit, such as labs, prescription medications, and procedures may apply cost sharing. See your plan's Schedule of Benefits for more information on the specific benefits that apply.

This is core to Our plans: We want You to use Your DPC early and often, which will help ensure that You stay healthy and in control of Your health.

Even better, We allow and encourage You to work with the same provider every time and across different communication channels like text, call, and in-person. This allows You to build a relationship with a doctor who knows You and what makes You unique, giving You care that is personalized specifically to You and Your needs.

How Your DPC Works for You

Your DPC provides and coordinates Your overall health care. Their job is to help You stay healthy, and not only when You are sick. Unless it is an Emergency, You should first contact Your DPC when You need medical services. They will often be able to provide the care directly, such as routine physical examinations, treatment of sickness or injury and administration of medically necessary injections and immunizations.

Direct primary care services include:

Everyday care	**Chronic conditions**	**Wellness and prevention**
● Annual physical exams ● Pre-operative clearance exams ● Allergies ● Colds and flus ● Headaches, migraines, and pains ● Skin rashes, moles, and lesions ● Cuts, scrapes, and minor injuries ● Stitches, sutures, and staple removal ● Sports injuries, like strains and sprains	● Diabetes and high blood sugar ● Overweight, obesity, and weight management ● Heart disease ● High cholesterol and hyperlipidemia ● High blood pressure and hypertension ● Asthma, COPD, and other respiratory issues ● Sleep apnea and insomnia	● Holistic care ● Diet and nutrition counseling ● Mental health ● Cardiovascular disease screening ● Flu shot and other vaccinations ● Smoking cessation ● Men’s health ● Women’s health ● Contraception counseling and family planning ● Travel health

• Upset stomach and diarrhea • Nausea and vomiting • Urinary tract infections (UTIs)	• Anxiety • Thyroid conditions and hypothyroidism • Arthritis and joint pain • Back pain • Acne and skin health	• Medical clearance • Basic cancer screenings

Your DPC Helps You Navigate Your Care

Your DPC will provide hands-on navigation if You need care or services outside of their scope. If Your DPC determines that You need specialized care, they can find an appropriate Network Specialist or coordinate any hospital care You may need. **While You do not need a referral to see another Network Provider, in order to maximize Your benefits under this Plan, We suggest that You work closely with Your DPC.** In most cases, they may be able to treat You directly, or they can suggest the best Network Provider for You.

Finding a Network Direct Primary Care Physician

Because Your DPC is so important to managing Your care, We allow You to choose the best DPC for You from Our network. To find a DPC in Taro's Network, visit www.tarohealth.com/network, enter your zip code, and click on the "Direct Primary Care" button listed under One-click Shortcuts. You can also get assistance by calling Member Services.

Please note that you do not need to notify Taro of your DPC selection. To begin care with a DPC, you simply need to contact a Network DPC directly to enroll with them and let them know that you are a Taro member.

While exploring Your options, You should talk to Your DPC about Your:

- Personal health history
- Family health history
- Lifestyle
- Any health concerns You have
- How they can help You

Changing Your Direct Primary Care Physician

If You wish to change Your DPC , you simply need to notify your current DPC that you want to end your membership with them and then enroll with the new Network DPC of your choice.

If Your DPC's participation in this network ends, We will notify You in writing and will provide You with a list of Network DPCs so You can choose a new one.

Continuity of Care

If a Provider You are seeing leaves Our network because We have terminated their contract without cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still receive network benefits. "Active treatment" includes:

1. An ongoing course of treatment for a life-threatening condition
2. An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits)
3. The second or third trimester of pregnancy and through the postpartum period
4. An ongoing course of treatment for a health condition for which the physician or health care

We will coordinate with Your current Provider to determine if discontinuing care by the current physician or provider would worsen Your condition or interfere with anticipated outcomes. An "ongoing course of treatment" includes treatments for mental health and substance abuse disorders.

In these cases, You may be able to continue seeing that provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same provider, You or Your doctor should contact Member Services for details. Any decision by Us regarding a request for continuity of care is subject to the appeals process.

Maintaining the Patient-Physician Relationship

Members enroll in this plan with the understanding that the DPC is responsible for determining appropriate treatment for the Member. For personal or religious reasons, You may disagree with the treatment recommended by their DPC or request treatment that the DPC or We judge to be incompatible with proper medical care. In the event of such disagreement, You have the right to refuse the recommendation of the DPC. If You do not adhere to recommended treatment or use non-recognized sources of care because of such disagreement, You do so with the full understanding that We have no obligation for the costs of such non-authorized care.

How To Find Other Providers in the Network

There are three ways You can find out if a provider or facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

1. View Our directory of Network Providers at tarohealth.com, which lists the doctors, providers, and facilities that participate in this plan's network.
    - Make sure to choose the correct Network Type that applies to your Plan from the dropdown menu (i.e., "Standard (w/ DPC)" if you are enrolled in a DPC plan, or "Clear Choice" if you are enrolled in a Clear Choice Plan.
2. Call Member Services to ask for a list of doctors and providers that participate in this plan's network, based on specialty and geographic area
3. Check with Your doctor or provider

If You need help choosing a doctor who is right for You, please reach out to Member Services.

Coverage of Other Providers

Taro Health does not just cover health care services rendered by physicians. We also cover services and procedures administered by other types of Network Providers as described below.

Clinical Professional Counselor
We cover health care services performed by a Network clinical professional counselor licensed in the State when those services are Covered Services under the Plan when performed by any other health care provider and those services are within the lawful scope of the practice of the clinical professional counselor.

Dentist
We provide coverage for health care services performed by a Network dentist licensed in this State when those services are Covered Services under the Plan when performed by any other health care provider and those services are within the lawful scope of practice of the dentist.

Naturopathic Doctor
We provide coverage for health care services performed by a Network naturopathic doctor licensed in this State when those services are Covered Services under the Plan when performed by any other health care provider and those services are within the lawful scope of practice of the naturopathic doctor.

Physicians Assistant
We provide coverage for health care services performed by a Network physician assistant licensed in this State when those services are Covered Services under the Plan when performed by any other health care provider and those services are within the lawful scope of practice of the physician assistant.

We will authorize a physician assistant to bill Us and receive direct payment for a medically necessary service provided to an enrollee and identify the physician assistant as provider in the billing and claims process for payment of the service.

Note: For covered services rendered by a naturopathic doctor and/or physician assistant, any Deductible, Copayment or Coinsurance cannot exceed the Deductible, Copayment or Coinsurance applicable to the same service provided by other health care providers.

Psychologist's services
We cover benefits for psychologists' services to the extent that the same services would be covered if performed by a physician.

Registered nurse first assistants
We provide benefits for coverage for surgical first assisting benefits or services. We provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications.

Pastoral Counselors, Marriage and Family Therapists, Social workers and psychiatric nurses
We cover services of licensed pastoral counselors and marriage and family therapists, social workers and psychiatric nurses to the extent that the same services would be covered if performed by a physician.

Cost Estimation for Services

To obtain information on the estimated costs for obtaining a comparable health care service from Network Providers, as well as quality data for those Providers, to the extent available, please visit the health care costs information of the Maine Health Data Organization at https://mhdo.maine.gov/.

For purposes of this section, "comparable health care service" means non-emergency, outpatient health care services in the following categories:

1. Physical and occupational therapy services;
2. Radiology and imaging services;
3. Laboratory services; and
4. Infusion therapy services.

Additionally, You have access to a health plan cost estimator tool in Your Taro member portal by logging in to your account at www.tarohealth.com and clicking the "Log In" button. If you do not have a member portal account yet, you will need to first register for one.

Note: Your Provider may give You the option of paying that Provider's discounted cash price for health care services.

Utilization Review

In order to be covered under this Plan, a health care service must be listed as a Covered Service in the Plan documents and must be Medically Necessary. We review services to determine whether the services are or were Medically Necessary. This process is called Utilization Review.

Utilization Review includes all review activities, whether they take place prior to the service being performed (Prior Authorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 1-833-928-0569.

Utilization Review 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.

To be covered and be eligible for benefits under the Plan, all services and supplies must:

1. Be listed as a Covered Service in the Plan documents;
2. Be rendered by a Network Provider (except in the case of Emergency Services) within the scope of such provider's license or certification;
3. Be Medically Necessary;
4. Not be indicated as excluded from coverage in the plan documents
5. Be performed on the Member while that Member is an active member of the Plan; and
6. Have been approved by Us either before, during or after the services or supplies are administered, as applicable.

Services that are Non-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 Taro Health's maximum allowable amount for a given Covered Service.

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. See Your plan documents for the Cost-Sharing amounts.

Upon retroactive review and confirmation of medical necessity, We may impose a penalty of no more than $500 for failure to provide notification under Our utilization review program described below. We reserve Our right to deny a claim when an appropriate Utilization Review concludes that services or treatment rendered were not medically necessary.

Background Information; Duty of Provider

A Provider has an affirmative duty to submit to Us the background information necessary for Us to complete Our review and render a decision within the time period required above. If the Provider needs additional time to submit that required information, the Provider must inform Us in a timely manner. Nothing in this section requires a Provider to submit confidential information without a signed consent from the Member.

Prior Authorization

Please see Taro's Prior Authorization information, available at www.tarohealth.com or by calling 1-833-928-0569 for a complete list of services and benefits that require Prior Authorization and how to request Prior Authorization as needed.

Prior Authorization of Non-Emergency Services

Except for a request in exigent circumstances as described below, a request by a Provider for Prior Authorization of a nonemergency service will be answered by Us within 72 hours or 2 business days, whichever is less, in accordance with the following:

- Both the Provider and the Member on whose behalf the authorization was requested will be notified by Us of its determination.
- If We respond to a request by a Provider for Prior Authorization with a request for additional information, We will make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information.
- If We respond that outside consultation is necessary before making a decision, We make a decision within 72 hours or 2 business days, whichever is less, from the time of Our initial response.
- If We do not grant or deny a request for Prior Authorization within the time frames specified under this subsection, the request for Prior Authorization by the Provider is granted.

If Prior Authorization is granted for a service, Benefits will be paid as described in the plan documents, unless there is a reason to deny Benefits. If We grant Prior Authorization for a Covered Service that is based on information given to Us that is fraudulent or materially incorrect, We may retroactively deny Prior Authorization for that Covered Service. We will not deny payment for any Covered Behavioral Health Care Service or physical therapy service solely on the basis that the referral was made during an Urgent Care visit. We will not apply greater Cost-Sharing for an Urgent Care referral than a DPC.

Urgent Care Determinations

Expedited Review in Exigent circumstances

When exigent circumstances exist, We will respond to a Prior Authorization request no more than 24 hours after receiving the request.

Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-Formulary drug.

We will notify the Member, the Member’s designee if applicable, and the Provider of Our coverage decision.

Prior Authorization of Prescription Drugs Used for Assessment and Treatment of Serious Mental Illness

We will approve a Prior Authorization request for medication on Our Prescription Drug Formulary that is prescribed to assess or treat a Member's serious mental illness. For the purposes of this subsection, "serious mental illness" means a mental disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities.

Prior Authorization of Medication-Assisted Treatment for Opioid Use Disorder

We do not require Prior Authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment. We do not impose any Prior Authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder.

For the purposes of this section, “medication-assisted treatment” means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling.

Electronic Transmission of Prior Authorization Requests for Prescription Drugs

We accept and respond to Prior Authorization requests through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. For more information, call Us at 1-833-928-0569.

Concurrent Review Determinations

We will make Our determination within 1 working day after obtaining all necessary information.

For authorization of extended stay or additional services:

- We will notify the Member and the Provider rendering the service within 1 working day.
- Written notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

For Adverse Benefit Determination of concurrent review We will:

- Notify the Member and the Provider rendering the service within 1 working day.
- Continue the service without liability to the covered person until the covered person has been notified of the determination

Retrospective Review

For retrospective review decisions, We will make the decision within 30 days after receiving all necessary information. In the case of a certification, We may notify in writing You and the provider rendering the service. In the case of an Adverse Health Care Treatment Decision, We will, within 5 working days after making the adverse decision, notify in writing the provider rendering the service and You. We will not without adequate written notice to the Member prior to his or her receipt of previously authorized services render an adverse decision with regard to health care services authorized pursuant to prospective review, except where fraudulent or materially incorrect information was provided to Us at the time Prior Authorization was granted, and the information was relied upon by Us in rendering its approval.

When conducting Utilization Review or making a benefit determination for Emergency Services, We will provide benefits for Emergency Services consistent with the requirements of this subsection and any applicable state or federal rule.

Before We deny benefits or reduce payment for an Emergency Service based on a determination of the absence of an Emergency Medical Condition or a determination that a lower level of care was needed, We will conduct a Utilization Review done by a board-certified emergency physician who is licensed in the State, including a review of the Member's medical record related to the Emergency Medical Condition subject to dispute. If We request records related to a potential denial of or payment reduction for a Member's benefits when Emergency Services were furnished to a Member, a Provider has an affirmative duty to respond to Us in a timely manner. This paragraph does not apply when a reduction in payment is made by Us based on a contractually agreed upon adjustment for health care service.

Notice

We will provide written notification of any Adverse Health Care Treatment Decision, which will include:

1. The principal reason or reasons for the decision;
2. reference to the specific plan provisions on which the decision is based;
3. information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request;
4. 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 or information is necessary;
5. the instructions and time limits for initiating an appeal or reconsideration of the decision;
6. if the adverse health care treatment decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse health care treatment decision, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the covered person upon request;

8. a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rationale and review criteria;
9. a description of the expedited review process applicable to claims involving exigent circumstances;
10. the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
11. notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto; and
12. any other information required pursuant to the federal Affordable Care Act.

A notice issued by Us or Our contracted utilization review entity in response to a request by or on behalf of a Member for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under the Policy or Contract under which the Member is covered. Nothing in this subsection requires Us to provide coverage for services performed when the Member is no longer covered by the Plan.

Requirements for an Appeal of Adverse Health Care Treatment Decision

An appeal of Our adverse health care treatment decision must be conducted by a Clinical Peer. The Clinical Peer may not have been involved in making the initial adverse health care treatment decision unless additional information not previously considered during the initial review is provided on appeal. For the purposes of this subsection, "adverse health care treatment decision" does not include a carrier's rescission determination or a carrier's determination of initial coverage eligibility for coverage.

Important Information

Taro Health may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternative benefit if, in Taro Health's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt Your claim from medical review if certain conditions apply.

Just because Taro Health exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Taro will do so in the future, or will do so in the future for any other Provider, claim or Member. We may stop or modify any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider directory, on-line precertification list, or contacting the Member Services number on the back of Your ID Card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Prescription Drug Exception Process and Step Therapy

Internal Prescription Drug Exception Process

The Member, the Member's designee or the person who has issued a valid prescription for the Member may request and gain access to a clinically appropriate drug not otherwise covered by the Plan by following the Utilization Review process described above and this subsection.

We will notify the Member, the Member's designee if applicable, and the person who has issued a valid prescription for the Member of Our coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. If We grant coverage, We will provide coverage of the drug for the duration of the prescription, including refills.

See above for information regarding expedited review in exigent circumstances. If coverage is granted, We will cover the drug for the duration of the exigency.

If We approve a request under this subsection for a drug not otherwise covered by the Plan, We will treat the drug as an essential health benefit, including counting any Cost-Sharing toward the Plan's annual limit on Cost-Sharing and including it when calculating the Plan's actuarial value.

External Exception Review

If We deny an exception request for a non-formulary drug, You, Your designee, or Your prescribing physician may request an independent review organization review the exception request and the denial of that request.

The independent review organization will make its determination and We will notify You or Your designee and the prescribing physician (or other prescriber, as appropriate) no later than 72 hours after the time We receive the external exception review request. If the initial exception request is for an expedited review and that request is denied by Us, then the independent review organization would have to make its coverage determination and provide appropriate notification no later than 24 hours after the time it receives the external exception review request.

Step Therapy

When coverage of a prescription drug for the treatment of any medical condition is restricted for use by Us through the use of a step therapy protocol, the Member and prescriber may request a step therapy override exception determination from Us by following the prescription drug exception and utilization review processes described above.

Covered Services

The following services are defined as 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 a Non-Network Hospital to a 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. Non-Network ambulance Providers will be reimbursed at the lesser of the ambulance service providers rate or 180% of the Medicare rate for the transportation.

   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 Non-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 Non-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 or rotary wing transportation. For Emergency Services, We encourage Your Provider(s) to coordinate with Our Medical Management team in selecting an Air Ambulance provider, when possible. Taro Health 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 that You could be balance billed by the provider for charges that exceed the Allowed Amount.

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 and 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. Prior Authorization requirements are applicable for admission.

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 medically 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 medically 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 are not to exceed 24 hours.

4. **Anesthesia Services.** The Plan provides Benefits for anesthesia only if administered while a Covered Service is being provided. Anesthesia Services provided by certified registered nurse anesthetists (CRNA) is covered.

5. **Asthma Education.** The Plan provides Benefits for Taro Health 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 Disorder 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.

    A DPC, 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. **Bilirubin Screening.** The Plan provides preventive Benefits for bilirubin concentration screening for newborns, not part of blood-spot.

8. **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.

9. **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, Member following current Taro Health managed care guidelines and policies to determine medical necessity.
    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.

    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.

10. **Breast Reconstruction.** If a Member receives Benefits in connection with a mastectomy and the Member elects breast reconstruction in connection with such mastectomy, to the extent required by federal law, the Plan provides Benefits for, in a manner determined in consultation with the attending Physician and the Member:
    a. All stages of reconstruction of the breast on which a mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complications of the mastectomy, including lymphedemas.

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

11. **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.

12. **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.

13. **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 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.

14. **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 (to include physical therapy provided by a Chiropractor) are limited to 40 visits per Member per Calendar Year, combined with osteopathic manipulation visits.

    Osteopathic manipulation benefits are limited to 40 visits per Member per Calendar Year, combined with chiropractic visits.

    Depending on the services provided in a single appointment it is possible You may be financially responsible for Copay(s), Your Deductible and or coinsurance for a single date of service.

15. **Clinical Trials.** A Member is eligible for coverage for participation in an approved clinical trial if the Member meets the following conditions:

a. The Member has a life-threatening illness for which no standard treatment is effective;
b. The Member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;
c. The Member's participation in the trial offers meaningful potential for significant clinical benefit to the Member; and
d. The Member's referring Physician has concluded that the Member's participation in such a trial would be appropriate based upon the satisfaction of the conditions in (a), (b) and (c).

We will not deny a Member, who meets the above criteria, participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

We will cover routine patient costs but are not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

For the purposes of this section, "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.

16. **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. At average risk for colorectal cancer or
    b. At high risk for colorectal cancer.

    For purposes of this section, "Colorectal Cancer Screening" means all colorectal cancer examinations and FDA-approved laboratory tests recommended by a Provider in accordance with the most recently published nationally recognized evidence based clinical 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.

Preventive colonoscopies without Cost-Sharing are only eligible for members who meet the specific guidelines under the USPSTF.

Colorectal cancer evaluations for asymptomatic screenings may be considered preventive (age dependent), but colorectal cancer evaluations due to symptoms or suspected disease are considered diagnostic and are subject to routing plan Cost-Sharing.

17. **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 Taro Health's reimbursement form in order to be reimbursed under the Plan. The reimbursement form can be found within your member portal on Our website https://www.tarohealth.com. For more information about the reimbursement process, contact Member Services at 1-833-928-0569. Coverage includes sterilization procedures, and patient education and counseling.

    We cover contraceptive supplies, which includes all contraceptive drugs, devices and products approved by the FDA to prevent an unwanted pregnancy. We will cover at least one contraceptive supply within each method of contraception that is identified by the FDA to prevent an unwanted pregnancy and prescribed and/or administered by a Network Provider with no Cost-Sharing. If there is a therapeutic equivalent of a contraceptive supply within a contraceptive method approved by the FDA, We may provide coverage for more than one contraceptive supply and may impose Cost-Sharing as long as at least once contraceptive supply within that method is available without Cost-Sharing. If Your Network Provider recommends a particular contraceptive supply approved by the FDA for You based on a determination of medical necessity, We will defer to the Network Provider's determination and judgment and will provide coverage without Cost-Sharing for the prescribed contraceptive supply. We will provide coverage for the furnishing or dispensing of prescribed contraceptive supplies intended to last for a 12-month period, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of Your Network Provider. Contact Member Services at 1-833-928-0569 to confirm preventive coverage without Cost-Sharing for contraceptives.

    The Plan provides Benefits for non-publicly funded abortions with no Cost-Sharing.

18. **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 unless specified below.

19. **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.

20. **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.tarohealth.com or You may request a copy of the Formulary by calling Member Services at 1-888-876-5432.

    The Plan provides preventive screening benefits for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes. Testing first year postpartum and can be as early as 4-6 weeks postpartum. Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy. Repeat testing is indicated in women who were screened with hemoglobin A1c in the first 6 months postpartum regardless of the result.

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

22. **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 DPC or kidney specialist 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.

23. **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 are provided for the repair/replacement of a type of Durable Medical Equipment once every three Calendar Years. At the Plan's discretion, replacements may be covered when the DME is damaged beyond repair due to normal wear and tear, when repair costs exceed new purchase price or when a replacement piece of DME is required due to the Participant’s growth or other physical change or a change in the Participant’s abilities or medical condition occurs sooner than the three-year timeframe. Repairs, including, but not limited to, the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement. 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 covered Medically Necessary Durable Medical Equipment. Supplies for Durable Medical Equipment are not subject to any Durable Medical Equipment maximum applicable to the Plan. Batteries and replacement batteries are not covered except for implantable medical devices.

    The Plan provides Benefits for Prostheses. Prostheses are manufactured devices used to replace a missing body part and restore full or partial function.. Prostheses include artificial limbs and prosthetic appliances. Coverage extends to such prosthetic devices and supplies necessary for the proper functioning of the device, when ordered by a provider, medical necessity criteria are met, and is limited to the least expensive model that will adequately meet Your medical needs. The Plan also covers repair or replacement of such prosthetic devices that is determined to be appropriate by a Provider and adheres to manufacturer repair and replacement guidelines. 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 or cosmetic purposes or that provide enhanced performance beyond functional activities of daily living.

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. However, the Cost-Sharing amount for Prosthetic devices to replace arms and legs, in whole or in part, including hands and feed, will not exceed 20% coinsurance after deductible. Please see Your Schedule of Benefits for more information. The Plan does not provide Benefits for replacement of Durable Medical Equipment due to being lost, stolen, or damaged due to weather.

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

25. **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 DPC.

    If You are hospitalized at a Network or Non-Network Facility, You or Your Designee should call Taro Health at 1-833-928-0569 within 48 hours or as soon as You can. If You are unable to notify Us, You may be responsible for any services that are determined to be not Medically Necessary or may be financially responsible for services provided once You become Stabilized, if You are at a Non-Network Facility.

    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 Inpatient Cost-Sharing as described in Your Schedule of Benefits.

Medically Necessary Emergency Services will be covered whether You get care from a Network or Non-Network Provider within the United States. Your responsibility for payment for Covered Non-Network Emergency Services is limited so that if You have paid Your share of the charge as specified in the Plan for Network services, We will hold You harmless from any additional amount owed to a Non-Network Provider for Covered Emergency Services and make payment to the Non-Network Provider in accordance with 24-A M.R.S. § 4303-C (as amended by PL 2019, ch. 668) or, if there is a dispute, in accordance with 24-A M.R.S. § 4303-E (as enacted by PL 2019, ch. 668).

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

a. The amount negotiated with Network Providers for the Emergency Service;
b. The amount for the Emergency Services calculated using the same method Taro Health generally uses to determine payments for Non-Network services but substituting the Network Cost-Sharing for the Non-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 a Non -Network Provider, Covered Services will be covered at the Non-Network level. Benefits provided until Your medical condition is Stabilized. Upon Stabilization Contact Taro Health for assistance finding a Network Provider.

26. **Eye Examinations.** The Vision Plan and its associated benefits only cover Members through the end of the month in which they turn age 19. The Plan provides one routine eye exam, including refraction, every 12 calendar months, with a Network VSP Provider for covered Vision Plan Members. Services and materials from a Non-Network Provider are not covered.

    The Plan does not provide Benefits for the fitting or purchase of eyeglasses or contact lenses, except as covered under “Eye Vision Hardware”.

    The Member’s Medical Plan provides a one-time preventative visual acuity screening, with no Cost-Sharing, for children between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors. This is a preventive service.

Medical and surgical treatment of injuries and illnesses of the eye are Covered Services under the Member's Medical Plan.

27. **Eye Vision Hardware.** The Vision Plan and its associated benefits only provides coverage for lenses and Otis & Piper frames, or contact lenses once every 12 months, to Members through the end of the month in which they turn age 19, with a Network VSP Provider. Services and materials from a Non-Network Provider are not covered.

    The following lenses and lens enhancements are covered in full: Impact-resistant plastic or glass lenses, single vision, lined bifocal, lined trifocal or lenticular lenses, and scratch-resistant or ultraviolet coating. The Vision Plan offers frames from the Otis & Piper collection covered in full.

    Contact lenses are in lieu of frames and lenses. Necessary and elective contact lenses are covered in full once every 12 months. Elective contact lenses have the following service limitations: Standard (one pair annually) = 1 contact lens per eye (total 2 lenses), Monthly (six-months' supply) = 6 lenses per eye (total 12 lenses), Bi-weekly (three-months' supply) = 6 lenses per eye (total 12 lenses), Dailies (three-months' supply) = 90 lenses per eye (total 180 lenses).

    Additionally, the Member's Medical 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.

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

28. **Fertility Coverage**. The Plan covers fertility diagnostic care, fertility preservation services, and fertility treatment as described in this section. Fertility Coverage includes coverage for the following services and procedures when recognized as medically appropriate, in light of the fertility patient's medical history:
    a. Artificial insemination;
        i. Benefits for intrauterine insemination is limited to three lifetime cycles
    b. Assisted hatching;
    c. Diagnosis and diagnostic tests;
    d. Fresh and frozen embryo transfer;

e. Egg retrievals, unless the egg retrieval patient has already undergone four completed egg retrievals, provided that:
    i. Where a live donor is used in an egg retrieval, the medical costs of the donor associated with the retrieval shall be covered until the donor is released from treatment by the reproductive endocrinologist; donor medical costs include without limitation physical examination, laboratory screening, psychological screening, and prescription drugs;
    ii. Egg retrievals where the cost was not covered by any carrier, self-insured health plan, or governmental program shall not count toward the four completed egg retrieval limit;
f. Gamete intrafallopian tube transfer and zygote intrafallopian tube transfer;
g. Intracytoplasmic sperm injections;
h. In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;
i. Medications, including injectable Infertility medications. Infertility drugs are covered under this Plan's prescription drug coverage;
j. Ovulation induction;
k. Surgery, including microsurgical sperm aspiration; and
l. Costs associated with cryopreservation and storage of sperm, eggs, and embryos

Benefits for any combination of in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or fresh or frozen embryo transfer (FET) is limited to two lifetime cycles.

The Fertility preservation services mentioned above includes the procurement and preservation of gametes, embryos, and reproductive material and storage from the time of cryopreservation for a period of 5 years.

29. **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.

30. **Freestanding Imaging Centers.** The Plan provides Benefits for covered Diagnostic Services performed by Freestanding Imaging Centers that are appropriately licensed. All services must be ordered by a Provider.

31. **Gender-Affirming Surgery.** The Plan covers Gender-Affirming Surgery (male to female; female to male) that is considered Medically Necessary. Prior Authorization is required.

Please call Member Services at 1-833-928-0569 Monday-Friday, 8am-6pm if You have any questions regarding coverage for these services.

32. **Habilitative and Rehabilitative 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.

    Habilitative and Rehabilitative Physical Therapy and Occupational Therapy is limited to 20 visits per Member per Year, combined. Habilitative and Rehabilitative Speech Therapy is limited to a total of 60 total combined visits per Member per Year, combined.

    A Member may obtain Medically Necessary speech therapy, physical therapy, occupational therapy for a maximum of 12 visits by submitting a complete report to Taro Health within 10 working days after the first consultation with the Member. Taro Health 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. Taro Health 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;
    - 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 will submit a report 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 Authorization is required from Taro Health before We will cover additional visits.

    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 above, 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.

33. **Health Care Services for Covid-19**. This Plan provides coverage for screening, testing and immunization for COVID-19.

Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings:

- *COVID-19* means the coronavirus disease 2019 resulting from SARS-CoV-2, severe acute respiratory syndrome coronavirus 2, and any virus mutating from that virus.
- *Surveillance testing program* means a structured program of asymptomatic testing at a community or population level to understand the incidence or prevalence of COVID-19 in a group. Surveillance testing program does not include a program of testing that occurs less often than once per month per individual.

Testing. This Plan covers screening and testing for COVID-19 as follows.

- We cover for screening and testing for COVID-19, except when such screening and testing is part of a surveillance testing program.
- We do not impose any Deductible, Copayment, Coinsurance or other Cost-Sharing requirement for the costs of COVID-19 screening and testing, including all associated costs of administration.
- Coverage without Cost-Sharing as required above is not dependent on any Prior Authorization requirement
- Coverage without Cost-Sharing as required above is not dependent on Your use of a Network Provider unless We offer You screening and testing by a Network Provider without additional delay and You choose instead to get screening from a Non-Network Provider or to be tested by a Non-Network Lab.

Immunization; COVID-19 Vaccines. We provide coverage for the COVID-19 vaccine as follows.

- We provide coverage for any COVID-19 vaccine licensed or authorized under an Emergency use authorization by the United States Food and Drug Administration that is recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to a Member.
- We will not impose any Deductible, Copayment, Coinsurance or other Cost-Sharing requirement for the cost of COVID-19 vaccines, including all associated costs of administration.
- Coverage without Cost-Sharing as required above is not dependent on any Prior Authorization requirement.
- Coverage without Cost-Sharing as required above is not dependent on the use of a Network Provider unless You are offered immunization by a Network Provider without additional delay and You choose instead to obtain immunization from a Non-Network Provider.

34. **Hearing Care.** The plan provides Benefits for routine hearing examinations for screening and for wearable Hearing Aids for covered Members. Coverage is limited to one routine screening exam for hearing-impairment and one hearing aid for each hearing-impaired ear every 36 months per Member through age 18. For Members aged 19 and older with documented hearing loss, hearing aids are covered up to $3,000 per 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. Benefits are provided for cochlear implants for Covered persons who are 18 years of age or less. 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.

35. **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 Taro Health, and then provide the services approved by Taro Health.

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.

There is no requirement that hospitalization be an antecedent to coverage under this Policy.

36. **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 Taro Health upon request.

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

38. **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.

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

40. **Infant Formulas and Donor Breast Milk.** 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. The Plan also provides coverage for Medically Necessary pasteurized donor breast milk.

Taro Health may require that a Provider confirm and document at least annually that the formula and/or breast milk remains Medically Necessary.

The Cost-Sharing for formula and/or breast milk is treated as Durable Medical Equipment for purposes of the Schedule of Benefits.

41. **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.

    An alternate infusion location such as home-based infusion may save You money over Facility-based infusion. The Plan may offer incentives for certain medical/pharmaceutical services to be obtained through specific Providers to encourage the use of low cost Providers. Ask Your Provider if home-based infusion is an appropriate option for You. Call Member Services at 1-833-928-0569 Monday-Friday, 8am-6pm, if You need assistance finding a Network home-infusion Provider.

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

43. **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 semi-private 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 (See cardiac rehabilitation section above for more information);
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.

Preauthorization is required for Inpatient Hospital Services. The Plan provides Benefits for a private room if Medically Necessary and Approved by Taro Health.

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 Taro Health that You are no longer eligible for continued Inpatient Stay at a Hospital.

44. **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 a 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.

45. **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.

46. **Maternal Depression Screening.** The Plan provides preventive Benefits for maternal depression screening for mothers of infants once during pregnancy and during the infant's well visits at 1, 2, 4, and 6-months of age.

47. **Medical Care.** The Plan provides Benefits for adult and pediatric medical care and services including office visits, consultations, Hospital, Urgent Care and Skilled Nursing Facility visits. Coverage for pediatric services continues until the end of the plan year in which the enrollee turns 19 years of age.

48. **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.

49. **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 Disorders. An established plan of treatment may be required. This includes Inpatient, Outpatient, residential, and Day Treatment Program services for Mental Health and Substance Use Disorder when You receive them from a Provider. In addition to other Network Providers, Mental Health and Substance Use Disorder treatment provided by Network licensed counselors may be covered.

    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 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. Applied Behavioral health services
    b. Room and board, including general nursing;
    c. Prescription drugs, biologicals, and solutions administered to inpatients;
    d. Supplies and use of equipment required for detoxification and rehabilitation;
    e. Diagnostic and evaluation services;

f. Intervention and assessment;
g. Facility-based professional and ancillary services;
h. Individual, group, and family therapy and counseling;
i. Medication checks;
j. Psychological and Neuropsychological testing; and
k. 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.

Please note that any Prior Authorization requirements for Mental Health and Substance Use Disorder treatment will not be more stringent than Prior Authorization requirements for other medical and/or surgical services. Please reach out to customer service at 1-833-928-0569 for additional information on Prior Authorization requirements.

50. **Morbid Obesity.** The Plan provides Benefits for surgery for an intestinal bypass, gastric bypass, or gastroplasty for treatment of Morbid Obesity. A pre-surgical psychological evaluation is required.

    The Plan does not provide Benefits for weight loss medication.

51. **Nutritional Counseling.** The Plan provides Benefits for nutritional counseling when required for a diagnosed medical condition.

52. **Obstetrical Services and Newborn Care.** The Plan provides Benefits for prenatal, delivery and postpartum 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. If a newborn receives services that are beyond the scope of routine newborn care Prior Authorization must be obtained.

    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. Prior Authorization is required for continued stay beyond 48 hours after a vaginal delivery or 96 hours following a cesarean section.

Home-birth
Home birth services are covered when performed by a licensed Provider within the scope of the Provider's license.

53. **Office Visits.** The Plan provides Benefits for office visits to Network Providers. Office visits include visits to Network retail health clinics and Network walk-in centers and are covered as Office Visits. Services at a Network retail health clinic are limited to basic health care services to Members on a walk-in basis. These clinics are normally found in major pharmacies and retail stores. Services are typically provided by nurse practitioners or physician's assistants and without an appointment. Services are limited to routine care and treatment of common illnesses for adults and children.

    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.

    Preventive Services
    If an item or service described as Preventive Care and Well-Care Services below:
    1. Is billed separately (or is tracked as individual encounter data separately) from an office visit, then Your Cost-Sharing requirements apply with respect to the office visit.
    2. Is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then We will not impose Cost-Sharing requirements with respect to the office visit.

    In other words, services related to a specific health concern, condition or injury will be separately billed as an office visit, subject to the Cost-Sharing requirements of Your Plan.

    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.

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

54. **Organ and Tissue Transplants.** As described in this section, the Plan provides Benefits for Preauthorized 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.

55. **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.

56. **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 Services;
    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 and may require Prior Authorization. Please check with Us to see if You are eligible for these Benefits or if You have questions about coverage.
o. Outpatient educational programs. Please check with Us to see if You are eligible for Benefits.

57. **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.

58. **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.

59. **Preeclampsia Prevention.** The Plan provides preventive screening benefits for preeclampsia screening in pregnant women with blood pressure measurements throughout pregnancy, at each visit.

60. **Prescription Drugs.** The Plan provides Benefits for FDA-approved prescription drugs and medicines listed on Taro Health's Formulary under prescription drug Benefits when dispensed by Network pharmacies. Prescription drug Out-of-Pocket Costs may vary depending on the tier that Taro Health assigns to the drug. Please see Your Schedule of Benefits for details.

    Prescription drugs dispensed by Network Providers and Facilities directly (such as medications provided to You as part of an Inpatient Hospital Stay, outpatient surgery, or during an office visit) are covered under medical Plan Benefits at the same Benefit as the place of service where the medication is dispensed.

    Note: Taro and/or its PBM may also, from time to time, enter into agreements that result in Taro receiving rebates or other funds ("rebates") directly or indirectly from

Prescription Drug manufacturers, Prescription Drug distributors or others. You will be able to take advantage of a portion of the cost savings anticipated by Taro from rebates on Prescription Drugs purchased by You under the terms of this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type. We (and Our Pharmacy Benefits Manager) will include Cost-Sharing amounts paid on behalf of Our Members when calculating the a Member's contribution to any Maximum Out-of-Pocket amount, Deductible or Copayment when a drug does not have a generic equivalent or was obtained through Prior Authorization, a step therapy override exception or an exception or appeal process. In other words, rebates received by Taro and payments made on behalf of the Member will be applied separately to any Cost-Sharing amounts. It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time You purchase the Prescription Drug, the amount the rebate applied to Your claim will be based on an estimate. Payment on Your claim will not be adjusted if the later determined rebate value is higher or lower than Our original estimate.

A copy of the current Formulary is available online at tarohealth.com or You may request a copy of the Formulary by calling Member Services at 1-888-876-5432. 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 Authorization. On the Formulary, medications that require Prior Authorization for coverage are marked accordingly.

Prescription Drugs must be prescribed by a licensed Provider and must be filled and dispensed by prescription through a licensed, Network Pharmacy.

Prescriptions must be used for their FDA-approved purpose unless Prior Authorization 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. We cover off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.

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

We will provide at least 60 days' written notice to an Enrollee of an adverse change to a formulary. Less than 60 days' notice is allowed when a drug is being removed from the formulary due to safety concerns.

Abuse-deterrent opioid analgesic drug products. We provide coverage for abuse-deterrent opioid analgesic drug products listed on Our formulary, preferred drug list or other list of drugs used by Us on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by this Plan.

Continuity of Prescription Drugs. If an enrollee has been undergoing a course of treatment with a prescription drug by Prior Authorization from another insurer and the enrollee's coverage with the other carrier is replaced with coverage from Taro Health, We will honor the Prior Authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the We conduct a review of the Prior Authorization for that prescription drug with the enrollee's prescribing provider.

We have a right to request a review with the enrollee's provider, and the We must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the Prior Authorization be continued. We are not required to provide benefits for conditions or services not otherwise covered under this Policy, and cost-sharing may be based on the Copayments and Coinsurance requirements of this Policy.

Contraceptives. We cover all prescription contraceptives or outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services.

HIV Prevention Drugs. If the FDA has approved one or more HIV prevention drugs that use the same method of administration, We will cover at least one approved drug for each method of administration with no out-of-pocket cost.

Diabetes Supplies. Benefits are provided for medically necessary equipment and supplies used to treat diabetes (insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets) and approved self-management and education training.

Eye Drops. We cover one early refill of a prescription for eye drops if the following criteria are met (Cost-Sharing may apply):

- The Member requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed;
- The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized;
- The refill requested by 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 health care provider prior to the request for an early refill; and
- The prescription eye drops are a covered benefit under this Plan.

Mental Illness Drugs. We will approve all Prior Authorizations for drugs to treat serious mental illness. No step therapy is required for such drugs. Serious mental illness means mental illness that results in serious functional impairment that substantially interferes with or limits one or more major life activities.

Orally Administered Cancer Therapy. We cover prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells. Please see the Formulary for a list of covered medications.

Emergency Supply of Maintenance Medications. A Network pharmacist may dispense an emergency supply of a Maintenance Medication to a patient without a prescription if the pharmacist is unable to obtain authorization to refill the prescription from a Network health care Provider and the pharmacist has a record of the prescription in the name of the patient, including the amount of the drug dispensed in the most recent prescription or the standard unit of dispensing the drug, and that record does not indicate that no emergency supply is permitted. A Network pharmacist may dispense an emergency supply of a Maintenance Medication to a patient as long as the following conditions are met:

1. The drug dispensed may not be a controlled substance included in Schedules I and II under the federal Controlled Substances Act;

2. The amount dispensed may not exceed a 30-day supply or, if the standard unit of dispensing exceeds a 30-day supply, may not exceed the smallest standard unit of dispensing, except that, if the drug is included on Schedule III or IV of the federal Controlled Substances Act, the amount dispensed may not exceed a 7-day supply;

3. The pharmacist may not dispense the Maintenance Medication in an emergency supply to the same patient more than twice in a 12-month period; and

4. The pharmacist must determine, in the pharmacist's professional judgment, that the prescription is essential to sustain the life of the patient or to continue therapy for a chronic condition of the patient and that failure to dispense the drug could reasonably produce undesirable health consequences or cause physical or mental discomfort.

Prescription Drug Coverage During Emergency Declared by the Governor. Except as provided in this subsection, We cover the furnishing or dispensing of a prescription drug in accordance with a valid prescription issued by a Provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor. This subsection does not apply to coverage of prescribed contraceptive supplies or coverage of opioids.

61. **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 or performed as medical surveillance (subsequent procedures with shortened interval due to personal risk factors) are not considered Preventive Care and Well-Care Services and will be subject to the Out-of-Pocket Costs described in the Schedule of Benefits. 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 are covered by the Plan with no Out-of-Pocket Costs for the Member when obtained by a Network Provider. 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 age appropriate screenings).

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 Network DPC or Pediatrician. You may call Member Services at 1-833-928-0569 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 Taro Health administers Preventive Services coverage, visit tarohealth.com or call Member Services at 1-833-928-0569. 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,
- Gynecological exams and pap tests,
- Routine vaccinations, and
- Flu and pneumonia shots.

62. **Prostate Cancer Screenings.** The Plan covers services for the early detection of prostate cancer if recommended by a Physician, at least once a year for men 50 years of age or older until a man reaches the age of 72. As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:
    A. A digital rectal examination; and
    B. A prostate-specific antigen test.

    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 may be provided at applicable Plan Cost-Sharing.

63. **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.

64. **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 above.

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

65. **Screening Mammograms and Diagnostic and Supplemental Breast Examinations.** 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. A screening mammogram also includes an

additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

The Plan provides Benefits for a diagnostic breast examination, which means a medically necessary examination of the breast, including an examination using diagnostic mammography, magnetic resonance imaging or ultrasound, that is:

1. Used to evaluate an abnormality seen on or suspected from a screening mammogram; or
2. Used to evaluate an abnormality detected by another means of examination.

The Plan provides Benefits for a supplemental breast examination, which means a medical examination of the breast, including an examination using diagnostic mammography, magnetic resonance imaging or ultrasound, to screen for breast cancer when there is no abnormality seen or suspected, but, based on personal or family medical history or other additional factors, the individual has an increased risk of breast cancer.

We cover a screening mammogram, diagnostic breast examination or supplemental breast examination performed by a Provider in accordance with this section with no Cost-Sharing.

Mammograms ordered to monitor a diagnosed condition are not screening mammograms and will be subject to Cost-Sharing.

66. **Second Opinions.** The Plan provides Benefits for second opinions when provided by a Network Provider with no practice association with the original Provider. You are not required to obtain a Second Opinion from a Provider that practices in the same office location as Your Provider, even if that office is the only Network Provider for the service. We will not apply a greater Cost-Sharing amount for the Second Opinion than if You received the Second Opinion in Network.

67. **Skilled Nursing Facility Services.** The Plan provides Benefits for Inpatient Skilled Nursing Facility services. The Plan does not cover Custodial Care.

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

68. **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 1-833-928-0569 Monday-Friday, 8am-6pm, if You need assistance finding a Network home sleep study Provider.

69. **Statin Medication.** The Plan provides preventive Benefits for statin medication for adults ages 40 to 75 at high risk.

70. **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 Taro Health surgical assistant codes. If You have questions about Your surgical procedure, please contact Your physician or Member Services at 1-833-928-0569.

71. **Telemedicine.** We provide coverage for Telemedicine services if the service would be covered if it were provided through in-person consultation and as long as the Provider is acting within the scope of practice of the Provider's license with regard to Telemedicine services. 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.

    Please note that not all services can be delivered through Telemedicine. Certain services require equipment and/or direct physical care that cannot be provided remotely. Also, please note that not all Providers offer Telemedicine services.

72. **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 and be filled and dispensed under a prescription order through a licensed Pharmacy.

    The Plan provides Benefits for tobacco cessation programs, follow-up education, and counseling as a preventive service.

73. **Transgender Health Services.** The Plan covers transgender health services that are considered medically necessary. Coverage includes medical and behavioral health provider visits, outpatient prescription drugs (hormone prescriptions are

processed without regard to gender), and gender-affirming surgery (requires Prior Authorization). Preventive services that are aligned with biologic anatomy are covered as preventive in accordance with the United States Preventive Service Task Force (USPSTF) “A” or “B” rating.

74. **Tuberculosis Screening.** The Plan provides preventive tuberculosis screening for certain adults without symptoms at high risk.

75. **Urinary Incontinence.** The plan provides preventive Benefits for yearly incontinence screenings for women.

Exclusions from Benefits

The Plan will not provide Benefits for: (1) anything that is not Medically Necessary; (2) anything provided before or after the dates coverage is effective (except as required by law); (3) Non-Covered Services and any services, items, or charges related to Non-Covered Services; (4) services, supplies, and any charges from a Non-Network or an excluded Provider (unless specified as Covered in this Agreement); (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 Non-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, nuclear explosion, nuclear accident or engaging in an illegal occupation.

2. **Acupuncture.** Benefits are not provided for the services of an acupuncturist unless comparable services would be covered if performed by a Physician.

3. **Administrative Examinations or Services.** The Plan does not provide Benefits for physical examinations and immunizations, unless required by law, needed 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, or
    n. other administrative purposes.

4. **Adult Vision Care.** The Plan does not provide Benefits for adult vision care or eye examinations except as described above. 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. However, discounted adult vision services may be available. Please reach out to customer service at 1-833-928-0569 for more information.

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

5. **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 Taro Health's Chief Medical Officer. These include, but are not limited to:
   a. Acupuncture, including auricular acupuncture treatment for addiction,
   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. Thermography,
   k. Orthomolecular therapy,
   l. Contact reflex analysis,
   m. Bioenergial synchronization technique, and
   n. 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.

6. **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 meet medical necessity criteria.

7. **Charges Above the Maximum Allowable Amount.** No Benefits are provided for charges above the Maximum Allowable Amount determined by Taro Health.

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

   This exclusion does not apply to Medically Necessary treatments for morbid obesity.

9. **Continuous Passive Motion Machines.** The Plan does not provide coverage for devices that passively (no patient effort) move the body.

10. **Cosmetic Services.** Except for reconstructive services described above, the Plan does not provide Benefits for Cosmetic Services that are not Medically Necessary, including but not limited to, the following services:
    a. Abdominoplasty
    b. Breast Reconstruction, including but not limited to:
        i. Reconstruction of a previously reconstructed breast due to normal aging;
        ii. Reconstruction of a breast that was not the result of a mastectomy;
        iii. The replacement of an existing breast implant if the earlier implant was performed as a cosmetic procedure
    c. Collagen Injections
    d. Dermabrasion
    e. Electrolysis or laser hair removal
    f. Hair transplantation
    g. Reversal of gender-affirming surgery and all related drugs and procedures
    h. Implantations
    i. Liposuction
    j. Lip reduction/enhancement
    k. Panniculectomy
    l. Removal of redundant skin
    m. Silicone injections
    n. Voice modification

    Please call Member Services at 1-833-928-0569 Monday-Friday, 8am to 6pm if You have any questions regarding coverage for these services.

11. **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 Taro Health.

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

13. **Dental Care.** Except as covered under above, 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 supernumerary 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.

14. **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.

15. **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 Taro Health 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 Taro Health
    - Mail service programs other than the Taro Health Approved or PBM's Mail Order Mail Service unless coverage is required by law
    - Drugs that are not included on the Formulary
    - Drugs that are not approved by the FDA
    - Legend (prescription) drugs that are not deemed Medically Necessary
    - Experimental or Investigational drugs

- Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine
- Therapeutic devices or appliances
- Anorectic or any other drugs used for the purpose of weight control
- Any drug used for cosmetic purposes
- Weight loss drugs
- Drugs filled without a prescription
- Drugs prescribed for impotence, erectile dysfunction, and/or sexual dysfunction
- Prescription refills in excess of the number specified by the prescribing Provider
- Prescription refills dispensed more than one year from the date of the original order
- Any portion of a drug for which Prior Authorization 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

16. **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 provides for the least expensive (and if applicable, lowest tech) equipment necessary to meet Your medical needs. The Plan does not cover duplicative Durable Medical Equipment. Batteries and replacement batteries are not covered except for implantable medical devices. For more information contact Member Services at 1-833-928-0569.

17. **Erectile or Other Sexual Dysfunction.** The Plan does not provide Benefits for any drugs, 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, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

18. **Experimental or Investigational Services.** The Plan does not provide Benefits for any drugs, supplies, services, laboratory tests 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 non-FDA approved services and FDA approved services must be used in accordance as approved by the FDA.

The Plan does not provide Benefits for laboratory tests that have not been approved by the FDA unless performed by a CLIA certified laboratory for medically necessary tests.

Statement for New Technology: Taro Health recognizes the need to evaluate coverage of new clinical technology and evidence based practice. Taro Health reviews requests to evaluate new technologies from a variety of sources. If You would like a copy of Taro Health's procedure for reviewing new technology, please call Member Services at 1-833-928-0569.

19. **Fertility Coverage**. The following services are not covered by the Plan:
    a. Reversal of voluntary sterilization;
    b. Medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by Us;
    c. Nonmedical costs of an egg or sperm donor;
    d. Experimental fertility procedures;
    e. Ovulation kits and sperm testing kits and supplies; and
    f. In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for Infertility, or who have exceeded the limit of four covered completed egg retrievals.

20. **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.

21. **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.

22. **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.

23. **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.

24. **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.

25. **Hearing Care.** No Benefits are provided for the replacement of lost, stolen, or damaged Hearing Aids.

26. **Hyaluronic Acid Injections.** The Plan does not provide coverage for Hyaluronic acid injections.

27. **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.

28. **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.

29. **Mandibular Advancement Oral Device.** The Plan does not provide coverage of oral appliances or devices that are generally created and fitted by dentists used to reduce upper airway collapsibility. Coverage is not provided for devices that may be adjustable or nonadjustable, custom or prefabricated and even if the device is prescribed or recommended by a medical or osteopathic doctor or medical provider to treat a specific medical condition.

30. **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 Taro Health 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.

31. **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 a Non-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.

32. **Non-prescription Birth Control.** The Plan does not provide Benefits for non-prescription birth control preparations unless the contraceptive method is only available over-the-counter. To get reimbursed for an over-the-counter contraceptive method, Your Provider must provide You with a prescription to submit with Your reimbursement. For more information about the reimbursement process, contact Member Services at 1-833-928-0569.

33. **Observation Care.** The Plan does not provide benefits for services that are considered inappropriate use of Observation services:
    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;
h. Unlisted procedures;
i. Genetic testing.

34. **Orthognathic Surgery.** The Plan does not provide Benefits for Orthognathic Surgery, except as covered under above.

35. **Orthotic Devices; Shoe Inserts.** The Plan does not provide Benefits for Orthotic Devices unless specified above. The Plan does not provide Benefits for shoe inserts except in certain cases for diabetic care.

36. **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).

37. **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.

38. **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.

39. **Personal Enrichment and Lifestyle Services.** The Plan does not provide Benefits for any of the following services or any services relating, but not limited to:
    a. Sensitivity training;
    b. Adult Children of Alcoholics (ACOA);
    c. Recreational or social programs;
    d. Sports camps and other camps;
    e. Life coaching;
    f. Religious counseling;
    g. Employment counseling;
    h. Sex therapy;
    i. Encounter groups;
    j. Self-help training or other forms of non-medical self-care;
    k. Vocational training;
    l. Educational programs except those provided in this Agreement;
    m. Marriage, relationship, guidance and career counseling; or
    n. Relaxation activities.

40. **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.

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

41. **Preventive Care.** The Plan does not provide Benefits for preventive care and well-care services, unless otherwise stated in this Agreement.

42. **Primary Care Services by Primary Care Providers other than a Direct Primary Care Physician (DPC)**. Primary care services performed by primary care providers that are not DPCs (with the exception of OB/GYN services for women and pediatricians for children), such as services from family medicine providers, will not be covered under your plan even if the provider is in Taro's network. Under Your plan, primary care must be provided by a DPC.

43. **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.

44. **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 above are Covered under the Plan. No other prostheses are covered.

45. **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.

46. **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.

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

48. **Reversing Gender Confirmation.** The Plan does not provide Benefits for services to reverse voluntarily induced surgical gender confirmation surgery.

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

50. **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.

51. **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 based camps or treatment programs.

52. **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.

53. **Services Received Outside the states of Maine or New Hampshire**. This Plan does not provide Benefits for Services received outside the states of Maine or New Hampshire, with the exception of the following services:
    - Emergencies services, including the facility, physicians or other providers you see as part of your Emergency visit;
    - services provided on a non-emergency basis at a Network facility by a Non-Network emergency Physician, assistant surgeon, surgical assistant, laboratory technician, radiologist, anesthesiologist, pathologist, or consulting Physician;
    - Urgent Care services;
    - Network Laboratory services; and
    - Network Durable medical equipment

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

55. **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.

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

57. **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.

58. **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.

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

60. **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 Taro Health 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.

Claims Payments

How to Ask Us to Pay You Back or to Pay a Bill You Have Received

Send Us a completed Claim Reimbursement Form, along with Your itemized bill from your Provider and documentation of any payment You have made. It's a good idea to make a copy of Your bill and receipts for Your records.

To make sure You are giving Us all the information We need to make a decision, You should fully complete the Claim Reimbursement Form and attach your itemized bill to your form. Make sure to sign the form before submitting it to Us. You can download a copy of the claim reimbursement form from the member portal on our website at tarohealth.com or call Member Services.

Note: If You request a claim form from Us, We will provide You with the proper form within 15 days. If We do not, You are deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

You can submit your form by either mailing it to Taro Health, PO Box 10110, Austin TX. 78766, via fax at (512) 233-7720, or by email at Claims@tarohealth.com.

You must submit written notice of Your claim to Us within 30 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on Your behalf to Us or Our authorized agent, with information sufficient to identify You, will be deemed notice to Us.

Contact Member Services if You have any questions. If You don't know what You should have paid, or You receive bills and You don't know what to do about those bills, We can help. You can also call if You want to give Us more information about a request for payment You have already sent to Us.

After You Submit a Request

When We receive Your request for payment, We will let You know if We need any additional information from You. Otherwise, We will consider Your request and make a coverage decision.

If We decide that the medical care or drug is covered and You followed all the rules for getting the care or drug, We will pay for Our share of the cost. If You have already paid for the service or drug, We will mail Your reimbursement of Our share of the cost to You. If You have not paid for the service or drug yet, We will mail the payment directly to the provider. These payments will be made within 30 days after We receive all of the requested information from You necessary to make Our coverage decision.

If We decide that the medical care or drug is not covered, or You did not follow all the rules, We will not pay for Our share of the cost. Instead, We will send You a letter that explains the reasons why We are not sending the payment You have requested and Your rights to Appeal that decision.

If You think We have made a mistake in turning down Your request for payment or You don't agree with the amount We are paying, You can make an Appeal. If You make an Appeal, it means You are asking Us to change the decision We made when We turned down Your request for payment.

For the details on how to make this appeal, please see the "If You have a complaint or an appeal" section of this document. The appeals process is a formal process with detailed procedures and important deadlines.

Undisputed Claims
An undisputed claim for payment of benefits under this Plan is payable within 30 days after proof of loss is received by Us. An "undisputed claim" means a manually or electronically submitted claim from a health care Provider or health care Facility that:

1. Contains all the required data elements necessary for accurate adjudication without the need for additional information;
2. Is not materially deficient or improper, including lacking substantiating documentation required by Us; and
3. Has no particular or unusual circumstances requiring special treatment that prevent payment from being made by Us.

Surprise Bills

As used in this section, “surprise bill” means a bill for health care services, including, but not limited to:

- Emergency services, received by an Enrollee for covered services rendered by an Non-Network Provider
- Services or procedures the Enrollee did not knowingly elect to obtain from a Non-Network Provider that were:
    - Rendered by a Non-Network Provider at a Network Facility; or
    - Previously approved or authorized by Us but rendered by a Non-Network Provider.

Note: “Surprise bill” does not include a bill for health care services received by an Enrollee when a Network Provider was available to render the services and the Enrollee knowingly elected to obtain the services from another provider who was a Non-Network Provider.

With respect to a “surprise bill” or a bill for covered Emergency Services rendered by a Non-Network Provider:

1. We require an Enrollee to pay only the applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a Network Provider. We will calculate any Coinsurance amount based on the median network rate for that service.
2. If We have an inadequate network, as determined by the superintendent, We will ensure that Members obtain the covered service at no greater cost than if the service were obtained from a Network Provider or We will make other arrangements acceptable to the superintendent.
3. Unless We agree otherwise with the Non-Network Provider, We will reimburse Non-Network Provider for ambulance services that are covered Emergency Services at the rate required by State law.

If You are Covered by More than One Policy

If You receive services that are covered by this 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. That is why it is so important that You tell Us when You have other insurance coverage in addition to Your Taro Health Plan. Please call Member Services at 1-833-928-0569 to let Us know about any additional coverage.

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.

Coordination of Benefits

Benefits under this Agreement 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, including, group and non-group health insurance contracts, HMO plans, nonprofit medical or hospital service corporation plans, and self-insured plans.

When You are covered by more than one Health Plan, one plan will be considered primary. The primary plan pays benefits first as though there was no other coverage. The benefits of secondary and tertiary plan(s) are determined after those of the primary plan. Secondary and tertiary plan benefits may be reduced by the primary plan’s benefit and capped at the primary plan’s Maximum Allowed Amount. When You are covered by more than one Health Plan, payments made by the primary plan, payments made by You, and payments made from a health savings account or similar fund for benefits covered under the secondary plan will be credited toward the Deductible of the secondary plan.

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 Taro Health's right to use any remedy provided by law to enforce Our rights to subrogation under this Agreement.

Cooperating with Taro Health

As a Member under the Plan, You agree to cooperate with Us in exercising Our rights of subrogation and COB under this Agreement. Taro Health 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 Taro Health's subrogation or COB rights;
- Providing Us with any information and documents that We request;
- Assigning to Taro Health payments that You receive for services paid by Taro Health;
- Signing documents deemed necessary by Taro Health to protect its subrogation and COB rights, including, but not limited to, providing Taro Health with Your prior written approval of Taro Health enforcing its subrogation rights; and
- Not taking any action that would impede Taro Health's subrogation or COB rights.

If You do not cooperate with Taro Health as provided in this section, You may be liable to Taro Health if We need to enforce its rights. You may also be liable for Our costs and reasonable legal fees.

If You Have a Complaint or an Appeal

Grievance Procedures

This document contains important information about how members can file Grievances with Taro Health. Members always have the right to contact the Maine Bureau of Insurance if there are questions or concerns regarding their coverage or appeals processes. The Maine Bureau may be contacted:

In Writing:
Maine Bureau of Insurance
State House Station 34
Augusta, ME 04333

Consumer Hotline: 800-300-5000

In addition, the Maine Attorney General and the Maine Superintendent have designated **Consumers for Affordable Health Care** as the **Maine Health Insurance Consumer Assistance Program** with support of a grant from the U.S. Department of Health and Human Services. You may call the Consumer Assistance HelpLine at 1-800-965-7476, reach them by mail at Consumers for Affordable Health Care, PO Box 2490, Augusta, ME 04338-2490, or find more information on their website: http://www.mainecahc.org/about-us/contact-us/.

Members have the right to ask Taro Health to review decisions involving requests to have claims paid. Members have the right to receive copies of any clinical review criteria Taro Health used to make an Adverse Benefit Determination.

For Adverse Benefit Determinations, the treating Provider has a right to request Reconsideration on behalf of the Member. This will be conducted within one working day of the request, between the treating Provider and the reviewing provider, or a peer if the reviewing provider is unavailable during the required timeframe.

Filing a Grievance

Members may submit a Grievance concerning any matter to Taro Health:

Name:	Taro Health
Address:	PO Box 10110 Austin, TX 78766
Phone:	(833) 928-0569
Fax:	(512) 233-7720

Per Maine law, the process and procedures for filing a Grievance depends on the nature of the Grievance.

- To file a Grievance regarding an Adverse Health Care Treatment Decision (i.e., a decision involving a medical determination), please see “Levels of Appeals Review for Grievances Concerning Adverse Health Care Treatment Decisions” and “Provision of Benefits During the Course of an Appeal” sections below.
- To file a Grievance concerning all other “Review Procedures for Grievances Concerning Matters Other than an Adverse Health Care Treatment Decision” section below.

Levels of Appeals Review for Grievances Concerning Adverse Health Care Treatment Decisions

Taro Health shall provide notice to the Member promptly of any Adverse Health Care Treatment Decisions, claim denial, or other matter by which the member is likely to be aggrieved. The notice shall state the basis for the decision, the right to file a Grievance, the procedure for doing so, and the time period in which the Grievance must be filed.

The following levels of review are available.

Standard Appeal

For Adverse Health Care Treatment Decisions, the treating provider has a right to request a reconsideration on behalf of the Member. This will be conducted between the treating provider and the reviewing provider, or a Clinical Peer if the reviewing provider is unavailable during the required timeframe. If the reconsideration process does not resolve the dispute, the Adverse Health Care Treatment Decision may be appealed by the Member or the provider on behalf of the Member. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination. Taro will make the rights of this section known to Members within 3 (three) working days after receiving an appeal.

Appeals will be evaluated by an appropriate Clinical Peer or peers. The Clinical Peer(s) will not have been involved in the initial Adverse Health Care Treatment Decision, unless new information is provided that had been unavailable at the time of the original decision.

Written notification of the appeal review decision will be made within thirty (30) working days following the request for an appeal. Additional time is permitted where Taro Health can establish that the 30-day time frame cannot reasonably be met due to the inability to obtain all necessary information. Any request for delay will be sent to the member and the

attending provider. In such instances, decisions will be issued within thirty (30) days of Taro Health's receipt of all necessary information.

The written decision will contain the following:

1. Names, titles and qualifying credentials of the person or persons evaluating the appeal;
2. A statement of the reviewer's understanding of the reason for the appeal;
3. Reference to the specific plan provisions upon which the decision is based;
4. The reviewer's decision in clear terms and the rationale in sufficient detail for You to respond further, if necessary;
5. A reference to the clinical review criteria (including any internal guidance or protocols) as well as evidence or documentation used to make the determination and instructions for requesting copies free of charge such information relevant to the claim; and
6. Notice of subsequent appeal rights as well as a description of the right to request an external review and time limitation for exercising those rights;
7. A statement that assistance may be available through an office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
8. A statement of a Member's right to contact the Superintendent's office for assistance at any time, as well as the toll free telephone number, website address, and mailing address of the Bureau of Insurance; and
9. Any other information required pursuant to the Affordable Care Act.

Second Level Appeal of an Adverse Health Care Treatment Decision

In any case where the standard appeal review process does not resolve a dispute between the member and Us, a written Grievance may be submitted, and Taro Health will review it as a second level Appeal.

A second level review panel will review the second level Appeal. A majority of the panel will be comprised of health care professionals who are Clinical Peers and who were not previously involved in the grievance (or subordinate to the health care professional previously involved in the grievance) and do not have a personal or financial interest in the outcome.

The review panel will hold a review meeting within thirty (30) working days after receiving a request for a second level review. The Member will be notified fifteen (15) working days in advance of the review date. Upon the Member's request, Taro Health will provide the Member all relevant information that is not confidential or privileged.

Members have the right to attend the second level review in person, present their case to the review panel, submit supporting material both before and at the review meeting, ask Taro Health questions, be assisted or represented by a person of their choice, and obtain his or her medical file and information relevant to the Appeal free of charge upon request. If the Member cannot attend in person, the Member may communicate with the review panel, at Taro Health's expense, by conference call, video conferencing or other available technology.

The review panel will provide a written decision within five (5) business days of the review meeting.

Decisions for second level grievance reviews will be issued within thirty (30) calendar days if the insured has not requested the opportunity to appear in person.

The decision notice will include the written decision information outlined above.

Expedited Appeals

Expedited Appeals of Adverse Health Care Treatment Decisions are available to a Member or a provider acting on the Member's behalf for any appeals involving a situation whether the time frame of the standard appeal procedures would seriously jeopardize the Member's life, health, or ability to regain maximum function. The expedited appeal will be conducted by a Clinical Peer or peers of the treating provider (or subordinate to the health care professional previously involved in the Grievance).

The appeal decision will be communicated telephonically within seventy-two (72) hours of the request for the expedited appeal and written confirmation will be provided within two (2) working days after the decision.

Independent External Review— In Accordance with 24-A M.R.S.A. § 4312

The Member has a right to request an independent external review of any Adverse Health Care Treatment Decision in which a professional medical opinion regarding a health condition is a material issue in the dispute. However, a Member may waive the right to a second level appeal and request an external review after the first level appeal decision.

Except for those situations which would require an expedited external review, Members enrolled in an individual health plan may request an external review after the Member has exhausted the first level of the internal grievance process (*i.e.*, appealed an Adverse Health Care Treatment Decision). A Member enrolled in a group plan may request external review only after the Member has exhausted both levels of the internal grievance

process. However, a Member may file a complaint with Maine Bureau of Insurance at any time.

The request for external review must be made within twelve (12) months of date the Member received the final Adverse Determination from Us. Requests are made to the Maine Bureau of Insurance. The Maine Bureau of Insurance oversees the external review process, including the independent review organization that conducts the review. An external review decision is binding on Taro Health and the Member.

There is no charge for the filing of the request for external review. The Taro Health Appeals and Grievances Department is available to assist Members by calling 1-833-928-0569. Members may ask for or submit information related to the benefit under review, attend the external review, and ask questions of the Taro Health representative at the review. If members wish to use any outside assistance for the review process, they will incur that expense themselves and it will not be subject to reimbursement.

Expedited Independent External Review

A Member enrolled in an individual plan is not required to exhaust the first level of Taro Health's internal grievance process if any of the circumstances listed immediately below apply. Similarly, a Member enrolled in a group health plan is not required to exhaust both levels of the internal grievance process before filing a request for external review if:

1. Taro Health failed to make a decision on an internal grievance within the time period required;
2. Taro Health and the Member mutually agreed to by-pass the internal grievance process;
3. The life or health of the Member is in serious jeopardy;
4. The Member has died; or
5. The Adverse Health Care Treatment Decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the Member has received emergency services but has not been discharged from the facility that provided the emergency services.

Provision of Benefits During the Course of an Appeal

Taro Health will not reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with 24-A MRSA § 4312.

Review Procedures for Grievances Concerning Matters Other than an Adverse Health Care Treatment Decision

The following review will be available to a Member concerning any matter except an Adverse Health Care Treatment Decision. For those types of grievances, refer to the "Levels of Appeals Review for Grievances Concerning Adverse Health Care Treatment Decisions" Section above.

For any Adverse Benefit Determination that does not involve a medical issue, Taro Health will provide the Member with written notice explaining the principal reason(s) for the determination and the basis for the determination, including any specific plan provisions or protocols. Taro Health will also provide a description of written material or information necessary to perfect the claim and why such information may be necessary. Further, Taro Health will include in this written notice instructions and time limits pertaining to a Member's right to initiate an appeal or reconsideration of the determination, including:

1. The telephone number the Member may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria;
2. A description of the expedited review process applicable to claims involving exigent circumstances;
3. Notice of the right to file a complaint with the Maine Bureau of Insurance;
4. A statement that assistance may be available through an office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
5. A statement of a Member's right to contact the Superintendent's office for assistance at any time, as well as the toll-free telephone number, website address, and mailing address of the Bureau of Insurance;
6. Any other information required pursuant to the Affordable Care Act; and
7. Upon request, information sufficient to identify the claim and diagnosis code involved.

A written grievance concerning any matter should be submitted to the address shown in the "Filing a Grievance" Section above.

Standard Appeal for Grievances Concerning Matters Other than an Adverse Health Care Treatment Decision

Members do not have the right to attend or to have a representative attend this type of review. Taro Health will notify the member within three (3) working days of Taro Health's receipt of the Grievance and the name, address and telephone number of the person who is coordinating the Grievance review.

Written notification of the grievance review decision will be made within thirty (30) working days of the Member's request. Taro Health may need additional time to gather necessary information and will send a request for such a delay to the member and the treating provider. Decisions will be issued within thirty (30) days of the receipt of all necessary information. The grievance review decision will not be conducted by the same person or person who made the initial determination regarding the matter.

The written decision will contain the following:

1. Names, titles and qualifying credentials of the person or persons conducting the review;
2. A statement of the reviewer's understanding of the reason for the grievance and relevant facts;
3. The reviewer's decision in clear terms and the basis for the decision, including any plan protocols relied upon in making the decision;
4. A reference to the evidence or documentation used as the basis for the decision;
5. Notice of the Member's right to request copies free of charge of relevant documents;
6. Notice of the Member's subsequent appeal rights as well as a description of the right to request an external review and time limitation for exercising those rights;
7. A statement that assistance may be available through an office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
8. A statement of a Member's right to contact the Superintendent's office for assistance at any time, as well as the toll-free telephone number, website address, and mailing address of the Bureau of Insurance; and
9. Any other information required pursuant to the Affordable Care Act.

Second Level Appeals Concerning Matters Other than an Adverse Health Care Treatment Decision

In any case where the standard appeal review process does not resolve a dispute between the Member and Taro Health, a written grievance may be submitted, and Taro Health will review it as a second level appeal.

A second level review panel will review the second level appeal. A majority of the panel will be comprised of Taro Health employees who were not previously involved in the grievance.

The review panel will hold a review meeting within thirty (30) working days after receiving a request for a second level review. The Member will be notified fifteen (15) working days

in advance of the review date. Upon the Member’s request, Taro Health will provide the Member all relevant information that is not confidential or privileged.

Members have the right to attend the second level review in person, present their case to the review panel, submit supporting material both before and at the review meeting, ask Taro Health questions, be assisted or represented by a person of their choice, and obtain his or her medical file and information relevant to the appeal free of charge upon request. If the Member cannot attend in person, the Member may communicate with the review panel, at Taro Health’s expense, by conference call, video conferencing or other available technology. Should Taro Health have an attorney present, Taro Health will notify the Member at least 15 days in advance and advise the Member of the right to obtain legal representation.

The review panel will provide a written decision within five (5) business days of the review meeting.

Decisions for second level appeals reviews will be issued within thirty (30) calendar days if the insured has not requested the opportunity to appear in person.

The decision notice will include the written decision information outlined above.

Accessibility

In any appeal under the grievance procedure, Taro Health shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by a Member who is visually impaired to allow the Member to exercise the Member's right to an appeal under this subsection.

When Membership Changes (Eligibility)

Subscriber Eligibility

To be eligible for membership as a Subscriber under this Certificate, the applicant must:

1. Be Determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be a United States citizen or national; or
3. Be a legal resident of Maine;
4. Submit proof satisfactory to Taro Health to confirm Dependent eligibility;
5. Agree to pay for the cost of the Premium
6. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7. Not be incarcerated (except pending disposition of charges);
8. Not be entitled to or enrolled in Medicare Part A without payment of Premium charge;
9. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, the service area is the area in which you:

1. Reside, intend to reside (including without a fixed address); or
2. Are seeking employment (whether or not currently employed); or
3. Have entered without a job commitment.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, the Dependent must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria and be:

1. The subscriber's legal spouse.
2. The subscriber's domestic partner. Domestic partner or domestic partnership means two individuals, of the same sex or opposite sex, that are each other's sole domestic partner; are mentally competent; at least 18 years old; who are not related in any way (including by blood or adoption) that would prohibit marriage under State law; not married to or separated from anyone else; and are financially interdependent.
    a. For purposes of this Certificate, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.
    b. A domestic partner's or a domestic partner's child's coverage ends at the end of the month of the date of dissolution of the domestic partnership.

c. To apply for coverage as domestic partners, both the subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the Exchange.

3. The subscriber's or the subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.
4. Children for whom the subscriber or the subscriber's spouse is a legal guardian, to the end of the month in which they turn age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. A Subscriber must furnish proof of a Dependent child's disability to Us within 31 days of the Dependent child's attainment of the limiting age of 26, and subsequently as may be required by Us. However, We will not require proof more frequently than annually after the 2-year period following the Dependent child's attainment of age 26. The Exchange must certify the Dependent's eligibility. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any Dependent. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Certificate unless required by the laws of this State.

Open Enrollment

An annual open enrollment period is provided for enrollees from:

- November 1 through December 15, for January 1st coverage; and
- December 16 through January 15 for February 1st coverage.

Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to modify and/or enroll in a plan.

Qualifying Events

You may be eligible for a Special Enrollment Period if one of the following occur:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay Premium charge;
- An individual gains access to health benefit plans as a result of a permanent move, provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move;
- Loss of Minimum Essential Coverage due to dissolution of marriage;
- Marriage;
- Adoption or placement for adoption; and
- Birth.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Certificate and You must pay Us timely for any additional Premium charge due.

An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. Preexisting conditions of an adopted child may not be excluded from coverage. The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption. Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's Certificate and You must pay Us timely for any additional Premium charge due.

The newborn of a member who is a Dependent child is eligible for benefits for Covered Services only from the moment of birth up to and including 31 days immediately following birth, but is not eligible for enrollment beyond this 31 day period under the Certificate until and unless the Subscriber/spouse or domestic partner is appointed by a court as legal guardian and can offer proof of such legal guardianship.

Adding a Child Due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Certificate must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Court Ordered Health Coverage

If You are required by a court order, as defined by applicable State or federal law, to enroll Your child under this Certificate, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Certificate and once approved by the Exchange, We will provide the benefits of this Certificate in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any dependent age limit. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date the Exchange receives a complete application with the applicable Premium charge payment.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date;
2. In the case of marriage, coverage is effective on the first day of the month after We receive a complete application, as long as the application is received within 60 days of the event; and
3. In the case where an individual loses Minimum Essential Coverage, coverage is effective based on when We receive a complete application, which must be submitted within 60 days of the qualifying event.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment;
6. Individual who no longer resides, lives or works in the plan's service area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. Termination of employer contributions; or
9. Exhaustion of COBRA benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber must notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium charge for persons no longer eligible for services will not obligate Us to pay for such services.

Family coverage should be changed to single coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to single coverage. The Exchange must be notified when a member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Notice to Parents

If the parent of a covered dependent requests, We will provide the parent with:

1. An explanation of the payment or denial of any claim filed on behalf of the covered dependent, except to the extent that the covered dependent has the right to withhold consent and does not affirmatively consent to notifying the parent;
2. An explanation of any proposed change in the terms and conditions of the Policy; or
3. Reasonable notice that the Policy may lapse, but only if the parent has provided Us with the address at which the parent may be notified.

4. In addition, any parent who is able to provide the information necessary for Us to process a claim is permitted to authorize the filing of any claims under this Policy.

Statements and Forms

Subscribers or applicants for membership must complete and submit to Us or the Exchange applications or other forms or statements We or the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is accurate. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a member may result in termination or rescission of coverage.

When Membership Ends (Termination)

Termination of the Member

Unless prohibited by law, the member's coverage will terminate if any of the following occurs:

1. The member terminates his/her coverage with appropriate notice to Taro Health.
2. The member no longer meets the eligibility requirements for coverage under this Certificate.
3. The member fails to pay his or her Premium charge, and the grace period has been exhausted.
4. Rescission of the member's coverage.

Effective Dates of Termination

Except as otherwise provided, Your coverage may terminate in the following situations. This information provided below is general, and the actual Effective Date of termination may vary based on Your specific circumstances; for example, in no event will coverage be provided beyond the date through which Premium charge is paid in full:

- If You terminate Your coverage, termination will be effective on the last day of the billing period in which the Exchange receives Your notice of termination.
- If the member moves outside of the service area, or the member is not located within the service area, coverage terminates for the member and all covered Dependents at the end of the billing period that contains the date the member failed to meet any of the conditions above regarding the service area.
- A Dependent's coverage will terminate on the date in which notice was received by the Exchange that the person no longer meets the definition of Dependent.
- If You permit the use of Your or any other member's plan identification card by any other person; use another person's card; or use an invalid card to obtain services, Your coverage will terminate immediately upon Our written notice. Any subscriber or Dependent involved in the misuse of a plan identification card will be liable to and must reimburse Us for the maximum allowed amount for services received through such misuse.
- If You stop being an eligible subscriber, or do not pay the required Premium charge, coverage terminates for all members at the end of the period for which Premium charge is paid subject to the grace period.

IMPORTANT: Termination of the Certificate automatically terminates all Your coverage as of the date of Termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if Your Certificate is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Certificate is guaranteed renewable, except as permitted to be terminated, canceled, rescinded, or not renewed under applicable State and federal law. The member may renew this Certificate by payment of the renewal Premium charge by the end of the grace period of the Premium charge due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage;
3. Membership has not been terminated by Taro Health under the terms of this Certificate.

Your coverage will not be canceled nor will You be denied renewal except for fraud or material misrepresentation and/or failure to pay premiums for coverage.

Loss of Eligibility

Coverage ends for a member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding Your eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premium charges or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Certificate, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on Your application, We may terminate or rescind this Certificate as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependent did not disclose on the application, We may terminate or rescind coverage for the additional Dependent as of his or her original Effective Date. We will give You at least 30 days written notice prior to rescission of this Certificate.

This Certificate may also be terminated if You engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if You knowingly participate in or permit fraud or deception by any provider, vendor or any other person associated with this Certificate. Termination will be effective 31 days after Our notice of

termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment or Coinsurance paid or Premium charge paid for such services. After the two (2) years following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Coverage

We can refuse to renew Your Certificate if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide You with at least ninety (90) days' notice of the discontinuation. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

After Termination

Once this Certificate is terminated, the former members cannot reapply until the next annual open enrollment unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period. You have the right to designate another person to receive notice of termination of this Certificate for nonpayment of charges or other lapse or default. We will send the notice to You and the person You designate at the last addresses You provided to Us 10 calendar days prior to cancellation of the contract.

You also have the right to change the person You designate if You wish. In order to designate a person to receive this notice or to change a designation, You must fill out a Third Party Notice Request Form. You can obtain this form by contacting Us.

Grace Period

If a Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the three month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or 31 days for individuals not receiving the APTC. If a Subscriber does not pay the required Premium by the end of the grace period, the Certificate is terminated. In order for a Premium to be considered paid during the grace period, We must receive it by the last

day of the grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Removal of Members

A subscriber may terminate the coverage of any enrolled dependent from the plan. If this happens, no benefits will be provided for Covered Services received after the dependent's termination date.

Refund of Premium Charge

Upon termination, We shall promptly return the unearned portion of any Premium charge paid.

Right to Reinstatement

You may be eligible to reinstate the Certificate within 90 days after the date of termination if non-payment of charges or other lapse or default took place because You suffered from cognitive impairment or functional incapacity at the time of termination. For the purposes of this provision, cognitive impairment or functional incapacity means a mental or nervous disorder of demonstrable origin that causes significant impairment.

If You request reinstatement, We may require a physician examination at Your own expense or request medical records that confirm You suffered from cognitive impairment, in order to continue Your coverage without a break in coverage. We will reinstate the same coverage You had before termination or the coverage You would have been entitled to if the Certificate had not been terminated, subject to the same terms, conditions, exclusions, and limitations. Before We can reinstate Your Certificate, You must pay the amount due from the date of termination through the month in which We bill You within 15 days from Our request. The charges will be the same amount they would have been if the Certificate had remained in force. If We deny Your request for reinstatement, We will send You a Notice of Denial. You have the right to an appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date You receive the Notice of Denial from Us.

Important Information About Your Coverage

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.

Autopsy Examination

Taro Health, at its own expense, has the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not prohibited by law.

Care Coordination

We pay Network Providers in various ways to provide Covered Services to You. For example, sometimes We may pay network providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed predetermined amount to cover the costs of Covered Services. In addition, We may pay network providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate network providers for coordination of member care. In some instances, network providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by network providers to Us under these programs.

Changes in Premium Charge

The Premium charge for this Certificate may change subject to, and as permitted by, applicable law. You will be notified of a change to Your Premium charge at the address in Our records 30 days in advance of the Effective Date of the change and You will be notified in 60 days prior to any rate filing that specifically impacts Your plan. If Premium charges have been paid beyond the Effective Date of the rate change, the Premium charge will be adjusted to comply with the change.

Premium Charges Paid by a Third Party

Taro Health will accept Premium charge payments made on behalf of subscribers if the Premium charge is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium charge and Cost-Sharing support for specific individuals;
- Indian tribes, tribal organizations and urban Indian organizations; or
- A relative or legal guardian on behalf of a subscriber.

Unless required by law, Taro Health does not accept Premium charge payments from third parties that are not listed above. Examples of third parties from whom Taro Health will not accept Premium charge payments include, but are not limited to, providers, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan.

Certificate Changes

We may change this Certificate at any time provided the changes have been approved by the Maine Bureau of Insurance, are in accordance with all applicable laws, and We send written notice 60 days in advance to the Member’s latest address in Our records. After We notify the Member of a change, payment of billed charges indicates the acceptance of the change.

Confidentiality

Any information pertaining to Your diagnosis, treatment or health obtained from either Your physician, provider or You will be held in confidence. We may use or disclose this information only to the extent required or permitted by law. Please refer to Taro Health's privacy protection annual notice for Our privacy policies and procedures.

Form or Content of Certificate

No agent or employee of Ours is authorized to change the form or content of this Certificate. Changes can only be made through a written authorization, signed by an officer of Taro Health.

Legal Action Against Taro Health

No action at law or in equity shall be brought against Taro Health by the Member or Member's representative to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Medical Policy and Technology Assessment

Taro Health reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental or Investigational status or medical necessity of new technology. Guidance and external validation of Taro Health's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including Taro Health's medical directors, doctors in academic medicine, and doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to medical necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Right of Recovery and Adjustment

Whenever payment has been made in error, We will have the right to recover such payment from You or, if applicable, the provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the Calendar Year in which the error is discovered.

We have oversight responsibility for compliance with provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

Statements and Representations

The statements You make on Your application for coverage with Us are representations and not warranties.

Severability

If any term or provision in this Certificate is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for Your injury or illness, You may be entitled to payment from a claim or legal action against that party. When We provide health care benefits for treatment of Your injury or illness, We have the right to recover, from any such payment (whether by judgment, suit, compromise, settlement or otherwise) up to the total benefit We paid, on a just and equitable basis. The process of recovering these expenses is called subrogation.

We also have subrogation rights against Your own insurance, including medical payments, uninsured, and underinsured motorist provisions in Your auto insurance policy.

Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to Your illness or injury are covered by a capitation fee, We are entitled to the reasonable cash value of the services.

By accepting plan coverage, You agree:

- Your signed application for coverage is Your authorization of Our right of subrogation;
- To notify Us of any event which could result in legal action, a claim against a third party, or a claim against Your own insurance;
- To notify Us of any payments You receive as a result of legal action, a claim against a third party, or a claim against Your own insurance;
- To cooperate with Us in exercising Our right of subrogation by providing all information requested;
- To sign documents We deem necessary to protect Our rights; and
- To do nothing to interfere with Our subrogation rights.

If You do not comply with the above, You may be responsible for expenses We incur in enforcing Our subrogation rights.

Time Limit on Certain Defenses

From the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability, as defined in the Policy, commencing after the expiration of such 3-year period.

Value-added Programs

Consistent with Maine law, We may offer health or fitness related programs and products to Our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are Non-Covered Services under the plan but are in addition to plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Certificate and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended time frame. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your plan. These programs are not guaranteed and could be discontinued at any time. We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which We encourage You to use for health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may

need to pay any Cost-Shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

Legal Notices

Right to Examine

This Certificate replaces any previous Certificates issued by Us.

Services provided during an inpatient stay that started during an existing Certificate will continue to be covered by the terms of that Certificate until You are discharged or reach any of the Certificate's limits or maximums, whichever occurs first.

If this Certificate is provided to You as a new member and You decide not to accept this Certificate, You may return it to Us at Taro Health Plan of Maine, Inc., 421 8th Avenue #1174, New York, NY 10116 within 10 days of its delivery to You and We will refund Your Premium payment. Please include a written request to cancel it. We will then refund any Premium charges less any claims paid under this Certificate.

Access to Information

The Member agrees that, except where restricted by law, Taro Health may have access to (a) all health record and medical data from health care providers covered under this Certificate and (b) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, homeowner's insurance and all types of health benefit plans that pertains to services You receive while a member of the plan.

Conformity with Law

If federal laws or the relevant laws of the State of Maine change, the provisions of this Certificate will automatically change to comply with those laws as of their Effective Dates. Any provision that does not conform with applicable federal laws or the relevant laws of the State of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Acknowledgement of Understanding

The Member hereby expressly acknowledges their understanding that this Certificate constitutes a contract solely between Member and Taro Health Plan of Maine, Inc, which is an independent corporation operating as a subsidiary of Taro Health, Inc. in the State of Maine. The Member further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Taro Health and that no person, entity, or organization other than Taro Health shall be held accountable or liable

to the Member for any of Taro Health's obligations to the Member created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Taro Health other than those obligations created under other provisions of this Agreement.

Definitions

The following terms, defined in this Section, are capitalized throughout this Certificate so they are easily identifiable.

Advance Payments of the Premium Tax Credit (APTC)
Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Adverse Benefit Determination
Includes both Adverse Health Care Treatment Decisions (involving medical determinations) as well as Adverse Benefit Determinations (insurance coverage decisions not involving medical determinations).

Adverse Health Care Treatment Decision
A medical decision denying, reducing or terminating in whole or in part payment for otherwise covered services based on Taro Health's utilization review and decision that the treatment is not considered medically necessary.

Allowed Amount (Maximum Allowed Amount)
The maximum amount the Plan will pay for a Covered Service. May also be referred to as eligible expense, payment allowance, or negotiated rate. For more information, see the "Claims Payments" section.

Appeal
A grievance relating to an Adverse Benefit Determination.

Benefit Period/Year
The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a Calendar Year for this Plan. If Your coverage ends earlier, the Benefit Period/Year ends at the same time.

Brand Drug
Prescription Drugs that We classify as Brand Drugs or Our Pharmacy Benefits Manager (PBM) has classified as Brand Drugs through use of an independent proprietary industry database.

Calendar Year
A period beginning on January 1 and ending on December 31 of the same Year

Clinical Peer

A physician or other licensed health care practitioner who holds a non-restricted license in a state of the U.S., is board certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of the carrier.

Coinsurance
The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

Copayment (Copay)
A fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service. The Copayment does not apply to the Deductible.

Cost-Share (Cost-Sharing)
The amount which the Member is required to pay for Covered Services. Where applicable, Cost-Share can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Services
The general term We use to mean all of the health care services, supplies, or treatments which are covered by Our plan. Such services, supplies, or treatments must be:

- Medically Necessary, specifically included as a benefit, and listed under the “What is Covered” section;
- Within the scope of the Provider’s license;
- Rendered while coverage under this Certificate is in force;
- Not Experimental or Investigational; and
- Authorized in advance by Us if such Preauthorization is required in this Certificate.

Deductible
The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your plan documents.

Dependent
A Member of the Subscriber’s family who meets the rules listed in the “When Membership Changes (Eligibility)” section and who has enrolled in the Plan.

Direct Primary Care (DPC)
The Primary Care Physicians (PCPs) in the Taro Health network are Direct Primary Care (DPC) physicians. A DPC is an individual who is a licensed physician or osteopathic physician or other advanced health care practitioner who is authorized to engage in independent medical practice in this State, who is qualified to provide primary care

services and who chooses to practice direct primary care by entering into a direct primary care service agreement with patients. The term includes, but is not limited to, an individual primary care provider or a group of primary care providers. They are different from traditional PCPs in that DPCs cap the total number of people they see in a year to allow them to have more time and flexibility for their patients, like You. This allows them to provide more attention and care during unrushed visits, which ultimately helps build a more trusted patient-physician relationship. Once You select the DPC that best fits You and Your needs, You will see the same physician consistently, whether it is in-person, over video (Telemedicine), or other modes of communication like phone calls, email, or even text.

Effective Date
The date when a Member's coverage begins under this Certificate.

Emergency Medical Condition
Emergency Medical Condition means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:

A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:
    1. Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;
    2. Serious impairment of a bodily function; or
    3. Serious dysfunction of any organ or body part; or
B. With respect to a pregnant woman who is having contractions, that there is:
    1. Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or
    2. A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital.

Emergency Service
"Emergency Service" means a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition that is provided in an emergency facility or setting.

Evidence of Coverage (EOC, Certificate of Coverage, Certificate or Agreement)
This document, which summarizes the terms of Your benefits.

Exchange

A governmental agency or non-profit entity that makes Qualified Health Plans such as this Plan available to Qualified Individuals.

Facility
A Facility including but not limited to, a Hospital, freestanding ambulatory surgical facility, chemical dependency treatment facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Certificate. The Facility must be licensed, accredited, registered and approved by the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Us.

Formulary
Listing of Prescription Drugs that are determined by Taro Health in its sole discretion to be designated as Covered Drugs under pharmacy plan Benefits. The list of approved Prescription Drugs developed by Taro Health, in consultation with physicians and pharmacists, has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Taro products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Taro. We may add or delete Prescription Drugs from this Formulary from time to time, consistent with applicable state law. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at tarohealth.com.

Generic Drugs
Prescription Drugs that We classify as Generic Drugs or that Our PBM has classified as Generic Drugs through use of an independent proprietary industry database. 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 Drug.

Grievance
A written complaint submitted by or on a Member's behalf regarding:

- the availability, delivery, or quality of healthcare services, including a complaint regarding an Adverse Benefit Determination made pursuant to Utilization Review;
- benefits or claims payment, handling, or reimbursement for health care services; or
- matters pertaining to the contractual relationship between the member and Taro Health; or
- Adverse Benefit Determinations.

Habilitative Services
Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or

talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Home Health Care Services (Home Health Care)
Health care services rendered in the place of residence on a part time basis to a Covered Person where:

1. Hospitalization or confinement in a Skilled Nursing Facility as would otherwise have been required if Home Health Care was not provided; and
2. A Physician prescribes a plan in writing covering the Home Health Care Services

Home Health Care Provider (Home Health Care Agency)
A Facility, licensed in the state in which it is located, which:

1. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services;
2. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse;
3. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day;
4. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician;
5. Has under contract the services of a physician-advisor licensed by the State or a physician;
6. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and
7. Maintains a complete medical record on each patient.

Identification Card/ID Card
A card issued by the Plan that bears the Member’s name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

Infertility
The presence of a demonstrated condition recognized by a Provider as a cause of loss or impairment of fertility or a couple's inability to achieve pregnancy after 12 months of unprotected intercourse when the couple has the necessary gametes for conception, including the loss of a pregnancy occurring within that 12-month period, or after a period of less than 12 months due to a person's age or other factors. Pregnancy resulting in a loss does not cause the time period of trying to achieve a pregnancy to be restarted.

Inpatient
A Member who receives care as a registered bed patient in a hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Intensive Outpatient Program
Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Mail Order Pharmacy
A service where You get Prescription Drugs (other than Specialty Pharmacy Drugs) through a mail order service.

Maintenance Medication
A Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Member Services at (888) 876-5432 or check Our website at www.tarohealth.com for more details.

Maintenance Pharmacy
A Network Retail Pharmacy that is contracted with Our PBM to dispense a 90 day supply of Maintenance Medication.

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:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of “best practices” in the medical profession; and
- Not primarily for the convenience of the Member or physician or other health care practitioner.

Member
The insured Member or other individual entitled to benefits under the insured Member’s Policy, and/or the Member’s representative or provider acting on the Member’s behalf.

Mental Health and Substance Abuse
A condition that is listed in the current edition of the DSM as a mental health or substance abuse condition.

Minimum Essential Coverage
Any insurance plan that meets the Affordable Care Act requirement for having health coverage. This plan provides Minimum Essential Coverage.

Network Pharmacy
A Network Pharmacy is a Pharmacy that has a Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. To find a Network Pharmacy near You, call Member Services at the telephone number on the back of Your Identification Card.

Network Providers
Health care Providers that have a written agreement with Taro Health to furnish health care services under this Certificate. Also referred to as participating Providers.

Non-Network Providers
Health care Providers that do not have a written agreement with Taro Health to furnish health care services under this Certificate. Also referred to as non-participating Providers. Providers who have not contracted or affiliated with Our designated subcontractor(s) for the services they perform under this Plan are also considered Non-Network Providers.

Out-of-Pocket Limit or Out-of-Pocket Maximum
The most You pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Limit does not include Your Premium Charge, amounts over the Maximum Allowed Amount, or charges for health care that Your Plan doesn't cover. When the Out-of- Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this document.

Outpatient
A Member who receives services or supplies when not an Inpatient.

Pharmacy
A place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your doctor.

Pharmacy Benefits Manager (PBM)
A Pharmacy benefits management company with which Taro Health contracts to manage Pharmacy benefits. Taro's PBM has a nationwide network of Retail Pharmacies, a mail service Pharmacy, and clinical services that include Formulary management.

The management and other services the PBM provides include, but are not limited to:

- Managing a network of Retail Pharmacies and operating a mail service Pharmacy.

- Taro's PBM, in consultation with Taro, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, Drug interactions or Drug/pregnancy concerns.

Plan
The set of benefits, conditions, exclusions and limitations described in this document.

Preauthorization (Prior Authorization)
Please see the section "Utilization Review" for details.

Premium
The monthly charge You must pay Taro Health to establish and maintain coverage under this Certificate.

Prescription Drug (Drug)
A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes Insulin, diabetic supplies, and syringes.

Prescription Order
A written request by a Provider, as permitted by law, for a Drug or medication and each authorized refill for the same.

Provider
A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Certificate. If You have a question about a Provider not described in this Certificate, please call the number on the back of Your Identification Card.

Qualified Health Plan or QHP
A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Individual
With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Referral
Please see the "How Plan Coverage Works" section for details.

Rehabilitative Services
Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Residential Treatment Center/Facility
A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either a Registered Nurse or Licensed Vocational Nurse/Licensed Practical Nurse) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more doctors available at all times.
3. Residential treatment takes place in a structured Facility-based setting.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial care
6. Educational care

Retail Pharmacy
An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a licensed pharmacist or Mail Order Pharmacy service upon an authorized health care professional's order.

Skilled Nursing Facility (SNF)
A Facility operated alone or with a Hospital that cares for You after a Hospital stay when You have a condition that needs more care than You can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission or the Bureau of

Hospitals of the American Osteopathic Association, or otherwise approved by Us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, custodial care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Specialty Care Physician (Specialist or SCP)
A physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician Specialist is a doctor who has added training in a specific area of health care.

Specialty Drugs
Drugs that are high cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at Retail Pharmacies.

Specialty Pharmacy
A Pharmacy that is designated by Us, other than a Retail Pharmacy or Mail Order Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

Subscriber
The Member who applied for coverage and in whose name this Certificate is issued.

Surgical Assistant
A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by Us who actively assists the operating surgeon in performing a covered surgical service.

Telemedicine
The delivery of healthcare or other health services using electronic communications and information technology, including: live (synchronous) secure video-conferencing; or secure instant messaging through Our app or website if available; interactive store and forward (asynchronous) technology, telemonitoring, and audio-only telephone. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of patient's physical and/or mental health.

Urgent Care
Medical care for an unexpected illness or injury that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room.

Urgent Care Center
A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care.

Utilization Review
Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section “Prescription Drugs Administered by a Medical Provider”), procedures, and/or Facilities.

We, Us, and Our
Taro Health (Taro).

Year and Yearly
A 12 month period.

You and Your
The Member, Subscriber and each covered Dependent.