Anthem Health Plans of Maine, Inc.

d/b/a Anthem Blue Cross and Blue Shield

Anthem Student Advantage
Anthem PPO
The University of Maine Systems
Effective August 1, 2020

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

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 Member Services at the number on the back of your Identification Card.

Right to Examine

If this Certificate of Coverage is provided to you as a new Member, and if you decide not to accept this Certificate, return it to our home office (Anthem Blue Cross and Blue Shield; 2 Gannett Drive, South Portland, ME 04106-6911) within 10 days after its delivery date. Please include a written request to cancel it. We will then refund any Subscription Charges less any claims paid under this Certificate.

Notices Required by State Law

Paying Subscription Charges and Renewal

Coverage is provided as stated in the Group Agreement. The coverage will renew automatically from year to year on the Anniversary/Renewal Date for additional one-year terms unless the Group or Anthem Blue Cross and Blue Shield gives written notice of termination, subject to the provisions in the Group Agreement.

Payment for subscription charges is due the first day of each month. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

Network Disclosure Notice

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS:
There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services, including "cost shares," such as co-insurance, co-payments, and out of pocket maximums may be higher if you use a non-network provider. Additionally, you may have some cost-sharing for preventive benefits if you do not use a network provider. Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, or contact Member Services for assistance.

Network Name: Blue Choice

The Service Area for this plan is the State of Maine.

Benefits are available both inside and outside the State of Maine. There are benefits for out-of-area non-Emergency Care/non-Urgent Care services. Please see the "Claims Payment" section for further details on out-of-area services through Our Inter-Plan program.

Federal Patient Protection and Affordable Care Act Notices

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Notice Regarding Breast Cancer Patient Protection Act
Under this plan, as required by the Maine Breast Cancer Patient Protection Act of 1997, coverage will be provided for inpatient care subsequent to the mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer for a period of time determined to be medically appropriate by the attending physician in conjunction with the patient.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits Medical Necessity criteria available upon request.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

Your University has agreed to be subject to the terms and conditions of Anthem BCBS's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your University, and the Plan that your University chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., University, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Student and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

The University may offer a separate program which allows you to receive services through a Student Health Center (SHC). Check with your University to learn more. If the University offers such a program, the Student should use the services the Student Health Center (SHC) first where outpatient/physician treatment will be administered or any required Referral issued.

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card 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. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclear.com/.

Kathleen S. Kiefer
Corporate Secretary

Table of Contents

Schedule of Benefits PPO

Actuarial Value: 82.29%

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" and Prescription Drugs section(s) section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	Plan Year

Deductible When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible The Deductible does not include amounts you pay for the following: • Services and Prescription Drugs from Student Health Center (SHC)	**In-Network**	**Out-of-Network**
Per Member	$250	$400

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays	80%	60%
Member Pays	20%	40%
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	**In-Network**	**Out-of-Network**
Per Member	$7,900	$15,800

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.

Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period.

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Acupuncture	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water) Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details Out of Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.	20% Coinsurance after Deductible	
Ambulance Services (Ground) Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details. Out of Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.	20% Coinsurance after Deductible	
Autism Services	Benefits are based on the setting in which Covered Services are received.	
Bariatric Surgery Services	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	
Blood Transfusions	Benefits are based on the setting in which Covered Services are received	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Chiropractor Services	See "Therapy Services."	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dental Services for Members through Age 18: Notes: To get In-network benefits, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call the number on the back of your ID card. Anesthesia for dentistry is available for certain members. Please see your Certificate of Coverage for details.		
Diagnostic and Preventive Services	0% Coinsurance no Deductible	0% Coinsurance no Deductible
Basic Restorative Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Services, Equipment, Education, and Supplies **Screenings for gestational diabetes are covered under "Preventive Care."**	Benefits are based on the setting in which Covered Services are received.	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	

Benefits	In-Network	Out-of-Network
Durable Medical Equipment (DME) and Medical Devices, and Medical and Surgical Supplies (Received from a Supplier)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics for limb replacement	20% Coinsurance no Deductible	20% Coinsurance no Deductible
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
Hearing Aids Benefit Maximum for Members through age 18: Benefit Maximum for Members age 19 and over:	One hearing aid per ear every 36 months Limited to $3,000 per hearing aid for each hearing impaired ear every 36 months	
Wigs (when needed after cancer treatment)	One wig per Benefit Period In- and Out-of-Network combined	
Early Intervention Services • For Members up to 36 months of age.	Benefits are based on the setting in which Covered Services are received	
Emergency Room Services		
Emergency Room Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
• Emergency Room Facility Charge	$200 Copayment per visit 20% Coinsurance after Deductible Copayment waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon) • Emergency Room Doctor Charge (Mental Health/Substance Abuse	20% Coinsurance after Deductible 20% Coinsurance after Deductible	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
Gene Therapy **Precertification required**	Benefits are based on the setting in which Covered Services are received.	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services for details on Benefit Maximums	
Home Care Covered Services include but are not limited to: - Intermittent skilled nursing services by an R.N. or L.P.N. - Medical / social services - Diagnostic services - Nutritional guidance - Training of the patient and/or family/caregiver - Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us. - Therapy Services - Medical supplies - Durable medical equipment		
• Home Care Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Dialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Infusion Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Specialty Prescription Drugs	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Home Care Services / Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Infusion Therapy	See "Home Care."	
Hospice Care		
• Home Hospice Care • Bereavement • Inpatient Hospice • Outpatient Hospice • Respite Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit.		

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant See "Inpatient Services" section for additional information regarding applicable cost shares. Please call us as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant.	Benefits are based on the setting in which Covered Services are received	
• **Transportation and Lodging Limit**	Covered as approved by us	
Inborn Errors of Metabolism: Medical Food	Benefits are based on the setting in which Covered Services are received	
Infant Formula	Benefits are based on the setting in which Covered Services are received	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Skilled Nursing Facility/Rehabilitation Benefit Maximum: 150 Days per Benefit Period for In-Network and Out-of-Network combined.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Maternity	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Intercollegiate Sports Accident	Covered in full up to $10,000 per accident, then deductible and coinsurance apply	
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services"	
The Office Visit Copayment will also apply to the first prenatal visit.		

Benefits	In-Network	Out-of-Network
Mental Health and Substance Abuse Services		
• Inpatient Mental Health / Substance Abuse Facility Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Residential Treatment Center Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Inpatient Mental Health / Substance Abuse Provider Services (e.g. Doctor and other professional Providers)	$30 Copayment no Deductible	40% Coinsurance after Deductible
• Outpatient Mental Health / Substance Abuse Provider Services (Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Outpatient Mental Health / Substance Abuse Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	$30 Copayment no Deductible	40% Coinsurance after Deductible
•		
• Office Visits,(including Online Visits and Intensive In-Home Behavioral Health Programs)	$30 Copayment no Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
• Student Health Center (SHC)	$10 Copayment no Deductible	Not applicable
• Primary Care Physician / Provider (PCP)	$30 Copayment no Deductible	40% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP)	$30 Copayment no Deductible	40% Coinsurance after Deductible
• Retail Health Clinic Visit	$30 Copayment no Deductible	40% Coinsurance after Deductible
• Online Visit (other than Mental Health & Substance Abuse; see “Mental Health & Substance Abuse Services” section for that benefit)	$30 Copayment no Deductible	40% Coinsurance after Deductible
• Counseling (includes Family Planning and Nutritional Counseling – other than for eating disorders)	$30 Copayment no Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Nutritional Counseling (for eating disorders)	$30 Copayment no Deductible	40% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
•		
• Diagnostic Lab (other than reference labs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Human Leukocyte Antigen Testing Limited to one test per lifetime per member to a maximum of $150. Any charges incurred in excess of $150 will be responsibility of the member.	20% Coinsurance Deductible does not apply	
• Diagnostic X-ray (non-preventive)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (non-preventive; including hearing and EKG)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy Services:		
- Chiropractic / Osteopathic / Manipulative Therapy*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Physical Therapy*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Speech Therapy*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Occupational Therapy*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Cardiac Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Acupuncture	20% Coinsurance after Deductible	40% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Outpatient Facility Services (including Freestanding Imaging Centers and Independent Laboratories)		
• Facility Surgery Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery Lab	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Human Leukocyte Antigen Testing – Limited to one test per lifetime per member to a maximum of $150. Any charges incurred in excess of $150 will be the responsibility of the member.	20% Coinsurance Deductible does not apply	
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests: EKG, etc.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Other (blood administration, removal of sutures or cast, removal of impacted or unerupted teeth, endoscopic procedures)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy:		
- Chiropractic / Osteopathic / Manipulative Therapy*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Physical Therapy*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Speech Therapy* -	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Occupational Therapy* -	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Cardiac Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	See “Therapy Services.”	
Preventive Care (including, but not limited to, colorectal screening, prostate cancer screening, mammogram, pap test, annual gynecological exam) 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 billed by your Provider For example, non-preventive x-rays or diagnostic tests performed during a preventive visit could be billed separately and may have a cost share.	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Prosthetics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	

Benefits	In-Network	Out-of-Network
Pulmonary Therapy	See “Therapy Services.”	
Radiation Therapy	See “Therapy Services.”	
Rehabilitation Services (including for head injuries)	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See “Therapy Services.”	
Skilled Nursing Facility	See “Inpatient Services.”	
Speech Therapy	See “Therapy Services.”	
Surgery (including, but not limited to, breast reduction surgery, symptomatic varicose vein surgery and bariatric surgery)	Benefits are based on the setting in which Covered Services are received.	
Telemedicine / Telehealth • **Primary Care Physician / Provider (PCP)** • **Specialty Care Physician / Provider (SCP)**	 $30 Copayment no Deductible $30 Copayment no Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services (including but not limited to inpatient and outpatient Infusion therapy, Inhalation Therapy and Massage Therapy)	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical & Occupational Therapy (Rehabilitative)	40 visits per Benefit Period	
• Physical & Occupational Therapy (Habilitative)	40 visits per Benefit Period	
• Speech Therapy (Rehabilitative)	40 visits per Benefit Period	
• Speech Therapy (Habilitative)	40 visits per Benefit Period	
• Manipulation Therapy (Rehabilitative)	40 visits per Benefit Period	
• Manipulation Therapy (Habilitative)	40 visits per Benefit Period	
• Cardiac Rehabilitation	Unlimited	
• Pulmonary Rehabilitation	Unlimited	
• Acupuncture	Unlimited	

Benefits	In-Network	Out-of-Network
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice or Autism benefit. **Note:** When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services / Walk-In Center (Office Visits)		
• Office Visit Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Labs (other than reference labs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Human Leukocyte Antigen Testing Limited to one test per lifetime per member to a maximum of $150. Any charges incurred in excess of $150 will be responsibility of the member.	20% Coinsurance Deductible does not apply	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

	In Network	Out-of-Network
Vision Services **Members through Age 18** To receive the In-Network benefit, you must use a Blue View Vision provider. Visit our website or call the number on your ID card for help in finding a Blue View Vision provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Routine Eye Exam (Once every calendar year)	$0 Copayment	Reimbursed up to $30
Standard Plastic Lenses Limited to one set of lenses per calendar year per member. • **Single Vision** • **Bifocal** • **Trifocal** Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network Providers.	 $0 Copayment $0 Copayment $0 Copayment	 Reimbursed up to $25 Reimbursed up to $40 Reimbursed up to $55
Frames Limited to one frame from the Anthem Formulary per calendar year per member.	$0 Copayment	Reimbursed up to $45
Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per calendar year per member. **Elective Contact Lenses** **Non-Elective Contact Lenses** **Important Note:** Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglasses until the next benefit period.	 $0 Copayment $0 Copayment	 Reimbursed up to $60 Reimbursed up to $210
Comprehensive low vision exam Limited to one per calendar year	$0 Copayment	Not Covered

	In Network	Out-of-Network
Optical/Non-optical aids/Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per calendar year.	$0 Copayment	Not Covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		

Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines. Note: For FDA-approved Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.	
Retail Pharmacy (In-Network and Out-of-Network)	90 days Note: A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.
Home Delivery (Mail Order) Pharmacy	90 days
Specialty Pharmacy	30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.

Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$15 Copayment per Prescription Drug	$15 Copayment 20% Coinsurance per Prescription Drug
Tier 2 Prescription Drugs	$45 Copayment per Prescription Drug	$45 Copayment 20% Coinsurance per Prescription Drug
Tier 3 Prescription Drugs	$75 Copayment per Prescription Drug	$75 Copayment 20% Coinsurance per Prescription Drug
Tier 4 Prescription Drugs	$75 Copayment per Prescription Drug	Not Covered

Note: You may also obtain up to a 90-day supply of maintenance medications at certain Maine retail pharmacies. You can learn whether your pharmacy participates in the Mail Service Prescription Drug Program by calling the Member Services Department at the number on your ID Card. A list of pharmacies participating in the program is also available online at www.anthem.com.

	In-Network	**Out-of-Network**
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$37.50 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$112.50 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$187.50 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	$75 Copayment per Prescription Drug	Not covered

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

How Your Plan Works

Introduction

Your Plan is a **PPO** plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We will determine the Medical Necessity of the service. Our determination will be based on our definition of Medically Necessary Health Care.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.

2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor'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.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and

You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider 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.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- 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.
- Check with your Doctor or Provider.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that we have several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Member Services to find out which network this Plan uses.

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.

Continuity of Care

If you are undergoing a course of treatment and the treating provider withdraws from this network, we will notify you of the termination. You may be allowed to continue receiving care from the withdrawing

provider for a period of 90 days from the date of notice of termination or through the end of postpartum care if you are in the second trimester of a pregnancy, if the provider:

- Agrees to accept the same rates of reimbursement that were in effect prior to the date of termination;
- Agrees to adhere to our applicable quality assurance standards and to provide us with the necessary medical information related to the care provided you; and
- Agrees to adhere to our policies and procedures.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard, which provides services to you when you are outside of our Service Area. If you are traveling outside of Maine and need care, you can find a doctor at **www.Anthem.com** or call us at the number on the back of your ID card. If you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center toll free number at 800-810-2583. Or you can call them collect at 804-673-1177.

For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.

  Precertification – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for your to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us with 48 hours of admission, or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

Continued Stay / Concurrent Review – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request.. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Provider must get Precertification when required.
Out of Network / Non-Participating	Member	• Member must get Precertification when required (Call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.

Blue Card Provider	Member (Except for Inpatient Admissions)	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • Blue Card Providers must obtain precertification for all Inpatient Admissions.
Note: For an Emergency Care admissions, precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescriptions Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the "Complaints and Appeals" section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	48 hours from the receipt of request
Non-Urgent Pre-service Review	72 hours or 2 business days from the receipt of the request, whichever is less.
Urgent/Concurrent Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request

Urgent/Concurrent Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	1 business day from the receipt of the request
Non-urgent Concurrent Continued Stay Review for ongoing outpatient treatment	1 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

Important Information

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or Provider arrangement 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 Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by checking your on-line Provider Directory 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 this Plan's Members.

Health Plan Individual Case Management

Our Health Plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions, including but not limited to Asthma, Heart Disease, Depression, Diabetes, High Blood Pressure & High Cholesterol, Low Back Pain and Pain. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read the "How Your Plan Works" section for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services." As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- 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, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met.

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

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 Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

a) A Doctor's office or clinic;
b) A morgue or funeral home.

Asthma Education

Benefits are provided for approved asthma education programs for our covered Members with asthma and their families. Benefits are provided when the program is received from an approved Network Provider.

Autism Spectrum Disorders

Your Plan provides coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

Please refer to your Schedule of Benefits for limits that may apply.

Behavioral Health Services

See “Mental Health and Substance Abuse Services” later in this section

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Blood Transfusions

Your 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.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

We provide Benefits for treating acute musculoskeletal disorders. We additionally provide Benefits for ancillary treatment, such as massage therapy, heat, and electro-stimulation, when performed in conjunction with an active course of chiropractic or manipulative/adjustive treatment. Such ancillary treatment may be subject to a deductible, based on service codes billed by the provider. Each type of service may be subject to different or multiple limits and/or other cost share, including copayments. We do not provide benefits for maintenance therapy for chronic conditions. See also “Manipulative/Adjustive Therapy”. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

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

Benefits are limited to the following trials:

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

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service; or
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Procedures

The Plan will provide benefits for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the member is classified as vulnerable. Examples of vulnerable members include, but are not limited to the following:

- Infants
- 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
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial or dental trauma
- Individuals who are extremely uncooperative, fearful or anxious

Dental Services

Independent Practice Dental Hygienist This plan will provide benefits secondary to dental coverage, if applicable, for covered services when those services are provided and billed by an Independent Practice Dental Hygienist.

Your Dental Benefits. Dental care treatment decisions are made by you and your dentist. We cover treatment based on what benefits you have, not whether the care is medically or dentally necessary. The only exception is when you get orthodontic care — we do review those services to make sure they're appropriate.

Pretreatment Estimates. When you need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it's best to go over a care or treatment plan with your dentist beforehand. It should include a "pretreatment estimate" so you know what it will cost.

You or your dentist can send us the pretreatment estimate to get an idea of how much of the cost your benefits will cover. Then you can work with your dentist to make financial arrangements, before you start treatment.

Dental Providers. Every plan has a network of dentists to choose from. You can go to any dentist, whether they're in your network or not. But you'll almost always pay less for the same level of care if you see a dentist in your network. Also, dentists in your network will send claims for care directly to us. When you go out of network, you may have to pay up front — then you'll submit claims to us for reimbursement.

For help finding a dentist in your network, log in to anthem.com/mydentalvision and go to Find a Doctor. When it asks for the type of doctor, choose dentist. You can also call the Member Services number on your dental ID card for help.

Pediatric Dental Covered Services

Pediatric Dental Essential Health Benefits. The following dental care services are covered for members until the end of the month in which they turn 19. All covered services are subject to the terms, limitations, and exclusions of this plan. See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams. Covered 2 times per 12 months.

Radiographs (X-rays): Bitewings – 2 sets per 12 months.
- Full mouth (also called complete series) – 1 time per 60 months.
- Panoramic – 1 time per 60 months.
- Periapicals and occlusal films.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months. Paid as child prophylaxis if member is 13 or younger, and adult prophylaxis starting at age 14.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 months..

Fluoride Treatment including topical application of fluoride or therapeutic fluoride varnish. Covered for members with moderate to high risk of dental decay.

Sealants or Preventive Resin Restorations. Any combination of these procedures is covered 1 time per tooth every 36 months.

Space Maintainers and Recement Space Maintainers.

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Consultations. Covered when given by a provider other than your treating dentist.

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kind of fillings covered under this plan:
- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling placed on a back tooth, we will pay up to the maximum allowed amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable deductible or coinsurance.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered 4 times per 12 months.

Endodontic Therapy on Primary Teeth
- Pulpal therapy
- Therapeutic pulpotomy

Periodontal Scaling and Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per quadrant per 24 months.
Resin Based Crown
Partial Pulpotomy for Apexogenesis. Covered on permanent teeth only.

Pre-fabricated or Stainless Steel Crown. Covered 1 time per 60 months for members through the age of 14.

Pin Retention

Therapeutic Drug Injection

Basic Tooth Extractions.
- Removal of coronal remnants (pieces of the crown portion of the tooth) on primary teeth.
- Extraction of erupted tooth or exposed root.

Surgical Incision and Drainage of an Abscess.

Endodontic Services

Endodontic Therapy. The following will be covered for permanent teeth only:
- Root canal therapy.
- Root canal retreatment.

Other Endodontic Treatments
- Apexification
- Apicoectomy
- Root amputation
- Hemisection

Periodontal Services

Full Mouth Debridement. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per lifetime.

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Only one of the below services is covered per single tooth or multiple teeth in the same quadrant per 36 months. Covered for permanent teeth only.
- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft

The following complex surgical periodontal care services are not subject to the benefit frequency stated above:
- Pedicle soft tissue graft.
- Free soft tissue graft
- Subepithelial connective tissue graft.
- Soft tissue allograft

Crown Lengthening.

Oral Surgery Services

Basic Extractions
- Removal of coronal remnants (retained pieced of the crown portion of the tooth) on primary teeth.
- Extraction of erupted tooth or exposed root.

Complex Surgical Extractions. Surgical removal of 3rd molars is covered only when symptoms of oral pathology exist.

- Surgical removal of erupted tooth.
- Surgical removal of impacted tooth.
- Surgical removal of residual tooth roots.

Other Complex Surgical Procedures
- Alveoloplasty
- Removal of exostosis – per site

Other Oral Surgery Procedures.
- Incision and drainage of abscess (intraoral soft tissue).
- Collection and application of autologous product. Covered 1 time per 36 months.
- Excision of pericoronal gingiva.
- Tooth reimplantation (accidentally evulsed or displaced tooth).
- Suture of recent small wounds up to 5 cm.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services.

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling. Inlays will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Onlays or Permanent Crowns. Covered 1 time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the maximum allowed amount for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable deductible and coinsurance.

Recement an Inlay, Onlay or Crown. Covered 6 months after initial placement.

Inlay, Onlay or Crown Repair. Covered 1 time per 36 months. The narrative from your treating dentist must support the procedure.

Implant Crowns. See the implant procedures description under Prosthodontic Services.

Restorative Cast Post and Core Build Up. Includes 1 post per tooth and 1 pin per surface. Covered 1 time per 60 months. Covered only if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

Prefabricated Post and Core (in addition to crown). Covered 1 time per tooth per 60 months.

Occlusal Guards. Covered 1 time per 12 months for members age 13 through 18.

Prosthodontic Services

Dentures and Partials (removable prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted.

Bridges (fixed prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 5 years has passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to service as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this plan in the last 60 months.

The plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the plan may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable deductible and coinsurance.

Tissue Conditioning.

Reline and Rebase. Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.

Repairs and Replacement of Broken Clasps.

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance and once 6 months has passed from the initial placement of the appliance and the narrative from the treating dentist supports the service.

Denture Adjustments.

Partial and Bridge Adjustments.

Recementation of Bridge (fixed prosthetic).

Single Tooth Implant Body, Abutment and Crown. Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. Some adjunctive implant services may not be covered. It's recommended that you get a pretreatment estimate, so you fully understand the treatment and cost before having implant services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. Your or your orthodontist should send it to us so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontic Care. This plan will only cover orthodontic care that is dentally necessary — at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite
- The position of you jaw or teeth impairs your ability to bite or chew
- On an objective, professional orthodontic severity index, your condition scores consistent with needing orthodontic care

What Orthodontic Care Includes. Orthodontic care may include the following types of treatment:

- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses and appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made a six month intervals until the treatment is finished or coverage under this policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this policy. We will not pay for any portion of your treatment that was given before your effective date under this policy.

What Orthodontic Care Does NOT Include. The following is not covered as part of your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this policy.

Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Diabetes Equipment, Education, and Supplies

The Plan provides benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program that is authorized by the State's Diabetes Control Project within the Maine Bureau of Health.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry

- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See “Therapy Services“ later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Hearing Aids

The Plan provides benefits for wearable hearing aids for covered Members. Coverage is limited. Please see the Schedule of Benefits for limits that apply. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing. Coverage is also provided for bone-anchored hearing aids.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

1) Artificial limbs and accessories;
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5) Restoration prosthesis (composite facial prosthesis)
6) Wigs (when needed after cancer treatment)
7) Cochlear implants

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Early Intervention Services

The Plan provides benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child's Primary Care Physician is required.

Please refer to your Schedule of Benefits for limits that may apply.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Medical Condition

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 Care

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service.

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

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

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service.

Stabilize, with respect to an Emergency Medical Condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility.

Foot Care

Benefits are provided for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Gene Therapy

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See "Getting Approval for Benefits" for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;
ii. Services provided by a non-approved Provider or at a non-approved Facility; or
iii. Services not approved in advance through Precertification.

Habilitative Services

Benefits are available for habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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.

Please see "Therapy Services" later in this section for further details.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services
- Medical supplies
- Durable medical equipment

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Abuse Services" section below.

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may also access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that

controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to of the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for the following Medically Necessary human organ and tissue transplants.

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.

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Prior Approval and Precertification

To maximize your benefits, you should call us as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.

- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Coverage for the cost of testing for bone marrow donation suitability

The Plan provides coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The covered 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 that is 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, 42 United States Code, Section 263a;

C. At the time of the testing, the covered member must complete and sign an informed consent form that authorizes the results of the test 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.

This benefit is limited to one test per lifetime.

Inborn Errors of Metabolism

The Plan provides benefits for metabolic formula and special modified low-protein food products. They 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.

Infant Formula

The Plan provides Benefits for amino acid-based elemental infant formula for children 2 years of age and under when a covered Provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. A covered Provider may be required to confirm and document ongoing medical necessity at least annually.

Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.

Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions:

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

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.

- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services, including infusion therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

The Plan provides benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis.

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive and Well Care" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

    - Observation and assessment by a physician weekly or more often,
    - Rehabilitation, therapy, and education.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.

- **Online Visits** when available in your area. Covered Services include a visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Please refer to the "Telemedicine" provision as you may have additional or different services available.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C),
- Licensed Pastoral Counselor or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Non-Emergency Care Outside of the United States

We provide Benefits for Inpatient and Outpatient services in a foreign Hospital. If you obtain Covered Services outside of the United States, in most cases you will have to pay your bill when you leave the Hospital.
When you return home, send the following to us with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your Contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When we receive this information, we will reimburse you for Covered Services according to the terms of this Contract.

Nutritional Counseling

Benefits are provided for nutritional counseling when required for a diagnosed condition.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care Services” benefit described earlier in this booklet.

Retail Health Clinic Care for limited basic health care services to Members without an appointment. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care / Walk-In Center Services as described in "Urgent Care / Walk-In Center Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Please refer to the "Telemedicine" provision as you may have additional or different services available. For Mental Health and Substance Abuse Online Visits, see the Mental Health and Substance Abuse Services section.

Prescription Drugs Administered in the Office as described in the "Prescription Drugs Administered by a Medical Provider" later in this section.

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services including head injury rehabilitation.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive and Well Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:

    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer (during a colonoscopy screening, samples of tissue may be collected for closer examination, or polyps/lesions may be removed),,
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity.

    Note: Coverage is provided for colorectal cancer screening for asymptomatic individuals at risk for colorectal cancer. Coverage also includes a colonoscopy when recommended as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    - Women's contraceptives, sterilization treatments, and counseling. This includes oral contraceptives as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy section."

      For FDA-approved contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to **1** pump per pregnancy**.**
    - Gestational diabetes screening.

    For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task force including:

    a. Counseling
    b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy
    c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

    a. Aspirin
    b. Folic acid supplement
    c. Bowel preparations

Please note that certain age and gender and quantity limitations apply. For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html

Covered Services also include these services as required by state law:

- Prostate Specific Antigen test and digital rectal examination for men

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation 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.

Please see "Therapy Services" in this section for further details.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “”Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Student Health Center Benefits

The Deductible will be waived and benefits will be paid at 100% for Covered Services incurred after a $10 copayment per visit when treatment is rendered at the University of Southern Maine and the University of Maine at Farmington Student Health Center.

The Deductible will be waived and benefits will be paid at 100% of the approved fee schedule after a $10 copayment per visit when treatment is rendered at the University of Maine Counseling Center.

The Deductible will be waived and benefits will be paid at 100% of the approved fee schedule when treatment is rendered at the University of Maine at Presque Isle and The University of Maine at Machias Student Health Center.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Bariatric Surgery / Morbid Obesity

The Plan provides benefits for the treatment of morbid obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required. Benefits are not provided for weight loss medications.

Breast Reduction Surgery

The Plan provides benefits for medically necessary breast reduction surgery.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries are not covered.

Benefits are limited to certain oral surgeries including:

- Surgical removal of impacted (wisdom) teeth;
- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services for Members through Age 18” for details.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. Please see the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Varicose Vein Surgery

Benefits are provided for medically necessary varicose vein surgery. Cosmetic surgery is not covered.

Telehealth

Covered Services that are appropriately provided by a Telehealth Provider will be eligible for benefits under this Plan when allowed by us. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health.

In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of your Identification Card.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy –** Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. Please see the "Chiropractic Services" provision earlier in this section for additional information.
- **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.
- **Acupuncture** – Treatment of neuromuscoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details. Benefits are also available for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers Prescription Drugs when they are administered to you as part of a Doctor's visit, home care visit or at an Outpatient Facility. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – 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.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; water vapor; therapeutic use of medical gases (including cabon dioxide, helium) or Drugs (including anesthetics) in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care / Walk-In Center Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care 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 health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:
- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services

Pediatric

These vision care services are covered for members until the end of the month in which they turn 19. To get In-Network benefits, you must use a Blue View Vision eye care provider. For help finding one, try "Find a Doctor" on our website, or call us at the number on your ID card. See the Schedule of Benefits to see your Deductible, Coinsurance, Copayment and other benefit limitations.

Routine Eye Exam

This policy covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of your vision.

Eyeglass Lenses

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28), progressive or lenticular.

There are a number of additional covered lens options that are available through your Blue View Vision provider. See the Schedule of Benefits for the list of options.

Frames

Your Blue View Vision provider will have a collection of frames for you to choose from. They can tell you which frames are included at no extra charge and which ones will cost you more.

Contact Lenses

Each benefit period, you can get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given benefit period. Your Blue View Vision provider will have a collection of contact lenses for you to choose from. They can tell you which contacts are included at no extra charge and which ones will cost you more.

- **Elective contact lenses** are ones you choose for comfort or appearance.

- **Non-elective contact lenses** are ones prescribed for certain eye conditions:
    - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses
    - High ametropia exceeding -12D or +9D in spherical equivalent
    - Anisometropia of 3D or more
    - For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: We will not pay for non-elective contact lenses for any member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when you have a significant loss of vision, but not total blindness. Your plan covers services for this condition when you go to a Blue View Vision eye care provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, , blood products, certain injectables and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order Pharmacy) section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration
- Specific clinical criteria including, but not limited to, requirements regarding age (based on FDA labeling), test result requirements, and/or presence of a specific condition or disease.
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies).
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.
- Use of an Anthem Prescription Drug List (a formulary developed by us) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

To be a Covered Service, Prescription drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book*: Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer, Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section “Getting Approval for Benefits” for more details.

If precertification is denied you have the right to file an appeal as outlined in the Complaints and Appeals” section of this Booklet.

Designated Pharmacy Provider

Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider’s office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider’s office.

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug**.**

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Continuity of Prescription Drugs

The Plan reserves the right to request a review of your previous insurance carrier’s prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier’s prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can deter mine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Provider in a medical setting (e.g., doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if prior authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain Prior Authorization in order for your to get benefits for certain Drugs. At times, your provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you and your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration
- Specific clinical criteria including, but not limited to, requirements regarding age (based on FDA labeling), test result requirements, and/or presence of a specific condition or disease.
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies).
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness, when clinically similar results may be anticipated.
- Use of an Anthem Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Anthem may, from time to time, waive enhance, change or end certain prior authorization and/or offer alternate benefits, if such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved contraceptives when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for information.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration) these will be covered under the "Preventive Care" benefit.
- Immunizations required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older.
- Prescription Drugs used to treat sexual or erectile dysfunctions or inadequacies.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Prescription Drugs used to treat sexual or erectile dysfunctions or inadequacies.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Certain In-Network retail pharmacies can fill your prescription at the same Copayments that apply to the mail order Pharmacy. Please ask your Pharmacy if they participate in this special arrangement or call the Member Services number on your ID for a list of participating pharmacies.

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the Appeals section of this booklet.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Provider. We will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers we offer within 31 days, we will select a single In-Network Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Complaints and Appeals" section of this Booklet.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is 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 the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will

change from time to time. We may require you or your doctor to order certain Specialty Drugs from a Specialty Pharmacy.

When you use the Specialty Pharmacy, a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Pharmacy
The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier. We will provide at least 30 days prior written notice of any modification to a formulary that results in the movement of a Prescription Drug to a tier with higher cost-sharing requirements.

Note: We and/or our designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain drug purchases under this Plan. These amounts will be retained by us. They will not be applied to your Deductible, if any, or taken into account in determining your Copayments or Coinsurance.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., byoral, injection, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

You may request a copy of the Covered Prescription Drug list by calling the Members Services telephone number on the back of your Identification Card or by visiting our website at www.anthem.com. The covered Prescription Drug List is subject to periodic review and amendment. Inclusion of a drug or related item on the covered Prescription Drug list is not a guarantee of coverage. Unless a Drug is being removed from the formulary due to safety concerns, we will provide 60 days written notice of an adverse change to the formulary to Members who are currently taking the Prescription Drug. An adverse change to the formulary includes the removal of a Prescription Drug from the formulary. It also includes moving the Prescription Drug to a higher cost share tier when such decision is not a result of the introduction to the market of a generic equivalent of that Prescription Drug.

Exception Request for a Drug not on the Prescription Drug List.

If you or your Doctor believes you need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours or 2 business days, whichever is less, of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision with 72 hours or 2 business days, whichever is less, of receiving your request. IF the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan.

We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug you have the right to request and external review by an IRO. The IRO will make a coverage decisions within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of your request or your Doctor’s request for an exception will only be provided if you are a Member enrolled under the plan.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits
Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. As required by Maine law, one early refill for prescription eye drops may be

available. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

Therapeutic Substitution
Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choice. Only you and your Doctor can determine if the therapeutic substitute is right for your. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program
The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you out of pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log onto the website at www.anthem.com.

Special Programs
Except when prohibited by federal regulations (such as H S A rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

Rebate Impact on Prescription Drugs You get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem 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 Anthem from rebates on Prescription Drugs purchased by you from Retail, Home Delivery, or Specialty Pharmacies under 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 Allowable 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.

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 of 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.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

Charges you pay for non-Covered Services do not count toward any Deductible, Coinsurance, or out-of-pocket limits.

1. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, or release of nuclear energy, a riot, or civil disobedience.

2. **Administrative Charges**

   Charges to complete claim forms,

   Charges to get medical records or reports,

   Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speed aid devices and tracheo-esophageal voice devices approved by Anthem.

4. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   - Holistic medicine,
   - Homeopathic medicine,
   - Hypnosis,
   - Aroma therapy,
   - Reiki therapy,
   - Herbal, vitamin or dietary products or therapies,
   - Naturopathy,
   - Thermography,
   - Orthomolecular therapy,
   - Contact reflex analysis,
   - Bioenergial synchronization technique (BEST),
   - Iridology-study of the iris,
   - Neurofeedback / Biofeedback.

5. **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.

6. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

   If you are an inpatient on the date your group cancels coverage with Anthem BCBS and you have care after the date your group coverage ends and your group has replacement coverage, the replacement carrier pays primary benefits for the inpatient care provided after the effective date and this Plan pays secondary benefits. If there is no replacement carrier, this Plan pays primary benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any contract maximums, when you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first

7. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers

8. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

9. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

10. **Clinically Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

11. **Clinical Trial Non-Covered Services** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

12. **Complications of/or Services Related to Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

13. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

14. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.

15. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

16. **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

17. **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

18. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services**.**
19. **Delivery Charges** Charges for delivery of Prescription Drugs.
20. **Dental Devices for Snoring** Oral appliances for snoring.
21. **Dental Services** Coverage is not provided for the following Dental-related services:
    - Dental care for members age 19 and older, unless covered by the medical benefits of this policy.
    - Dental services or health care services not specifically covered under the policy (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
    - Services of anesthesiologist, unless required by law.
    - Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
    - Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
    - Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    - Case presentations, office visits, consultations.
    - Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
    - Enamel microabrasion and odontoplasty.
    - Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the policy.
    - Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this policy.
    - Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this policy.
    - Separate services billed when they are an inherent component of another covered service.
    - Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
    - Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
    - Provisional splinting temporary procedures or interim stabilization.
    - Pulp vitality tests
    - Adjunctive diagnostic tests
    - Incomplete root canals
    - Cone beam images
    - Anatomical crown exposure
    - Temporary anchorage devices
    - Sinus augmentation.
    - Oral hygiene instructions.
    - Repair or replacement of lost or broken appliances.
    - Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
    - Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    - The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    - For dental services received prior to the effective date of this policy or received after the coverage under this policy has ended.

- Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this policy.
- Athletic mouth guards.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.

22. **Dental treatment** for injuries that are a result of biting or chewing, unless the chewing or biting results from a medical or mental condition. This Exclusion does not apply to services that we must cover by law.
23. **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
24. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits based on FDA labeling.
25. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
26. **Drugs that Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law, except injectable insulin.) This exclusion does not apply to over-the-counter drugs that we must cover under Federal law when recommended by the U.S. Preventive Services Task Force and are prescribed by a physician (contraceptives). For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org.
27. **Drugs Prescribed by Providers Lacking Qualifications/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications including certifications, as determined by Anthem.
28. **Educational Services** Services,,supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based..
29. **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.
30. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
31. **Eye Exercises** Orthoptics and vision therapy.
32. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
33. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

34. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies 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.
    - Other services that are given when there is not an illness, injury or symptom involving the foot.

35. **Foot Orthotics Foot** orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting lower limbs, such as severe diabetes, unless stated as covered in the "What's Covered" section of this certificate.

36. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

37. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

38. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), soley to increase or decrease height or alter the rate of growth.

39. **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

40. **Health Club Memberships and Fitness** Services Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

41. **Home Care**

    - Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    - Private duty nursing.
    - Food, housing, homemaker services and home delivered meals.

42. **Hospital Services Billed Separately** Services by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

43. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

44. **Infertility Treatment** Testing or treatment related to infertility.

45. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

46. **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.

47. **Medical Equipment, Devices and Supplies**

    - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

- Non-Medically Necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.

48. **Medicare** For which benefits are payable under Medicare Parts A, and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
49. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments**.**
50. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
51. **Non-approved Drugs** Drugs not approved by the FDA
52. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
53. **Off Label use** Off label use, unless we must cover it by law or if we, or the PBM, approve it. Prescription drugs approved by the Federal Drug Administration (FDB) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
54. **Oral Surgery** Extraction of teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
55. **Personal Care, Convenience and Mobile/Wearable Devices**
    - Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
    - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
    - Home workout or therapy equipment, including treadmills and home gyms,
    - Pools, whirlpools, spas, or hydrotherapy equipment.
    - Hypo-allergenic pillows, mattresses, or waterbeds,
    - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
    - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
56. **Private Duty Nursing** Private Duty Nursing Services, unless listed as covered in this Booklet. Your coverage does not include benefits for private duty nursing in the inpatient setting.
57. **Prosthetics** Prosthetics for sports or cosmetic purposes.
58. **Residential Accommodations** Residential accomodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care 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.
- 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.
- Wilderness camps.

59. **Routine Physicals and Immunizations** Physical exams and Immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

60. **Sanctioned or Excluded Providers** Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U>S> Department of Health and Human Services office of Inspector General List of Excluded Individuals/Etities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

61. **Sexual Dysfunction** Services or supplies for male or female sexual problems.

62. **Sport, Contest, or Competition** Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.

63. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

64. **Sterilization Services** to reverse an elective sterilization.

65. **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

66. **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

67. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs.

68. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

69. **Vision Services** Coverage is not provided for services incurred for or in connection with any of the items below:
    - Eyeglasses lenses, frames or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.
    - For safety glasses and accompanying frames.
    - For two pairs of glasses in lieu of bifocals.
    - For plano lenses (lenses that have no refractive power).
    - Lost or broken lenses or frames, unless the member has reached their normal interval for service when seeking replacements.
    - For services or supplies not specifically listed as covered in this Booklet.
    - Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
    - For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

70. **Waived Cost-Shares Out-of-network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

71. **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

72. **Wilderness or other outdoor camps and/or programs** Programs and/or outdoor camps, including but not limited to, Wilderness camps.

73. **Workers' Compensation** Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.
We will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met**:
    - You are making a claim under the Workers' Compensation Act;
    - Your health care coverage is provided through an employee health plan;
    - Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
    - The Workers' Compensation Board has not made a determination on your claim;
    - Your employer has made no payment on or settlement of your claim.

    Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

3. **Clinical Trial Non-Covered Services** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

4. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / 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 a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the "Prescription Drug List" in the section "Prescription Drug Benefits at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity limits set by the Plan or which are over any age limits based on FDA labeling.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
14. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. Whle not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy" benefit. Please see that section for details
16. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), soley to increase or decrease height or alter the rate of growth.
17. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
18. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
19. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the prescription drug benefit at a retail or home delivery (Mail Order) Pharmacy benefit may be covered under the Durable Medical Equipment and Medical Devices benefit. Please see that section for details.
20. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the 'Allergy Services' benefit. Please see that section for details.

21. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
22. **Non-approved Drugs** Drugs not approved by the FDA.
23. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
24. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
25. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

    Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
26. **Onychomycosis Drugs** Drugs for Onchomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
27. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under federal law with a Prescription. For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org
28. **Sanctioned or Excluded Providers** Any Drug, Drug regiment, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
29. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
30. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section

If the insured is covered as a dependent child, and if we receive a request from a parent of the insured, we will provide that parent with:

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

3. Notice of lapse. 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.

In addition, any parent who is able to provide the information necessary for us to process a claim must be permitted to authorize the filing of any claims under the policy.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. You may call the toll-free Member Services number on your ID card to determine the Maximum Allowed Amount for a particular Covered Service. Please see 'Inter-Plan Arrangements' later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary Health Care; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent

with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our network or non-network provider fee schedule/rate (as required by law), which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services

from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside Anthem's Service Are by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges unless we have authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies or you receive a surprise bill, if applicable.

Surprise Bill

The following only applies to Providers within the State of Maine:

A surprise bill is a bill for Covered Services, other than Emergency Services, received by a Member for services rendered by a Non-Network Provider at a Network Provider during a service or procedure performed by a Network Provider, or during a service or procedure previously approved or authorized by us; however, a surprise bill does not include a bill for Covered Services received by a Member if a Network Provider was available and the Member knowingly elected to obtain the services from a Non-Network Provider.

With respect to a surprise bill, a Member is only responsible for what the Member would have paid (any applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense) for a Network Provider. The Non-Network Provider within the State of Maine is prohibited by law from balance billing the Member.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You will not be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:
You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and we will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible, and within one year after the 90-day period ends (i.e. within 15 months), you may still be able to get benefits. However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied, unless an extension is required by federal law.

We will pay benefits for a claim under this policy or certificate within 30 days after proof of loss is received by us.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient’s relationship with the Student.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider’s signature.

We will furnish to the Member claim forms used for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the we receive notice of any claim under the policy, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. Where permitted by applicable law, we reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the University's Contract), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, we will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting Approval for Benefits" section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits When Members Are Insured Under More Than One Plan

Coordination of Benefits
All benefits of the contract are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers you, such as:
- Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for covered services as if there were no other coverage. The contract with secondary responsibility may provide benefits for covered services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All benefits are limited to the contract maximums or to the maximum allowance for the services you receive.

The following are non-Allowable expenses:

- The amount that is subject to the Primary high-deductible health plan's deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue code of 1986.

When you have duplicate coverage:
- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:
  1. **Pediatric Dental Coordination of Benefits (COB)**. These pediatric dental COB provisions are applicable to only the pediatric dental benefits found in the part titled What's Covered in the section Dental Services. If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be primary coverage and any standalone dental plan will be secondary. If the member has two medical plans, each offering pediatric dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determinations rules below apply.
  2. **Non-Dependent/Dependent** The benefits of the contract that covers you as an employee or subscriber will be determined before the benefits of the contract that covers you as a dependent are determined.
  3. **Dependent Children (Parents Not Legally Separated or Divorced)** For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this contract will determine the order of benefits.
  4. **Dependent Children (Parents Legally Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has

remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.

5. **Active/Inactive Employee** The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule six applies.
6. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
7. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they're necessary without notifying the covered persons.

Credit toward deductible

When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Subrogation and Reimbursement

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 approval and authorization of our right of subrogation on a just and equitable basis;
- 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 immediately notify us if a trial is commenced, if a settlement occurs or if potentially dispositve motions are filed in a legal action. Any payments you receive must not be dissipated or disbursed until such time as we have been repaid in accordance with these provisions.
- 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.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That also means giving you access to our network of health care providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of health care Providers.
  - Your rights and responsibilities.
  - The rules of your health Plan.
  - The way your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care you receive.
  - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.
- Get help at any time, by calling the Member Services number located on the back of your ID Card or by visiting www.anthem.com

  Or contact your local insurance department.

  Phone: (800) 300-5000
  Write: Maine Bureau of Insurance
  Department of Professional and Financial Regulation
  #34 State House Station
  Augusta, ME 04333-0034

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.

- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.
- Give us, your Doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Inform Member services if you have any changes to your name, address or family members covered under your Plan.

If you would like more information, have comments, or would like to contact us, please go to anthem.com and select Customer Support>Contact Us. Or call the Member Services number on your ID card.

We want to provide high quality benefits and Member Services to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Complaints and Appeals Process

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Complaints and Appeals

Complaints

Our Member Services Representatives are ready to help Members resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Member Services Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. Anthem will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for us to reconsider an adverse determination within one working day after we get the request. The review will be done by the person who made the adverse determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, Anthem will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If more information is needed, a final decision will be made within thirty (30) days after the added information is received. If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, we will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions.

Anthem will make the decision within one working day after getting all needed information.
In the case of a decision to approve a longer stay or more services, Anthem notifies the Member and the Provider rendering the service within one working day. The written notice will include the number of added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, Anthem notifies the Member and the Provider rendering the service within one working day. The service will continue without liability to the Member until the Member has been told of the finding.

Expedited Appeals. Anthem has a written process for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Member or would risk the Member's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Member or the Provider acting for the Member.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first adverse determination.

Anthem will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including Anthem finding, will be shared between Anthem and the Member or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, Anthem will make a decision and notify the Member and the Provider acting for the Member by phone as quickly as the Member's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Member until the Member has been notified of the finding.

If the first notice was not in writing, Anthem will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

Appeals

Level One Appeal Process

You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by a clinical peer or peers who have not been involved with a prior finding. In an appeal of an adverse health care treatment decision, you have the right to review the claim file. More information may be submitted by or for the Member, any treating physician, or Anthem as part of the internal process. A finding will be made within thirty (30) days after we receive the request for an Appeal.

The decision will include:

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Anthem in giving its first Adverse Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at 1-800-300-5000.

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at Anthem's expense by conference call, video conferencing or other appropriate technology to present your concerns with our adverse determination.

Level Two Appeal Process

On a level two appeal the entire record will be reviewed. Appeals of a clinical nature will be reviewed by a clinical peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Member, any treating Physician, or Anthem BCBS. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after we receive the Member's Level Two Appeal. A written decision will be sent to the Member within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Member may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Member, Anthem shall provide to the Member all information that was used for that finding that is not confidential or privileged.

A Member has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the Appeal procedures outlined under this section, the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

External Review Process

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by Anthem, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, and findings regarding experimental or investigational services. An adverse health care treatment decision is a decision made by us or on our behalf denying payment. The request must be made within 12 months of the date the Member has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- Anthem BCBS did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Member has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- Anthem BCBS and you both agree to bypass the internal Appeals process;
- The life or health of the Member is at risk;
- The Member has died; or
- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review. An external review finding must be made as quickly as a Member's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Member or would put the Member's ability to get back maximum function at risk.

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same adverse health care treatment decision for which you have already received an external review decision.

The Grievance should be sent to the following address:

For medical and Prescription Drug or Pharmacy Issues:
Anthem BCBS ME
Attention Appeals
PO Box 218
North Haven, CT 06473-0218

For Dental Issues:
Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 1122
Minneapolis, MN 55440-1122

For Vision Issues:
Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within two years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

Prescription Drug List Exceptions

Please refer to the “Prescription Drug List” section in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for the process to submit an exception request for Drugs not on the Prescription Drug list.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please contact your University or Benefits Department for details.

Who is Eligible for Coverage

The Student

All full-time are automatically enrolled in the Plan at registration and the premium for coverage is added to their tuition billing, unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements. Anthem maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If Anthem discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Types of Coverage

Your University offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Student only (also referred to as single coverage);

When You Can Enroll

Enrollment

Students are automatically enrolled if they are eligible.

Waiver of Coverage

A Student may waive coverage under this Plan if he/she provides proof that he/she has other adequate health coverage which meets the University's minimum requirements for coverage. The Student must complete a waiver form and timely submit it to the University.

The University will determine whether the Student's alternative health care coverage meets the minimum requirements.

Special Enrollment Periods

If a Student does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Student must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.

- Exhausted COBRA benefits or stopped receiving University contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:
- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Effective Date of Coverage and Special Enrollment Periods

If a Student does not apply for coverage when they were first eligible, they may be able to join the Plan if they qualify for Special Enrollment. Except as noted otherwise below, the Student must request Special Enrollment within 31 days of a qualifying event.

Effective Dates for Special Enrollment periods

1. 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
2. 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; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing:

    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - 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.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, sexual orientation or identity, gender.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for three years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the University and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your University leaves the association. It will be the University's responsibility to notify you of the termination of coverage.

- If you cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the University and/or you must notify us immediately. The University and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 31 calendar day written advance notice before your coverage is retroactively terminated or rescinded. Such notice will contain clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact; an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact; notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission; a description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and the date when the advance notice ends and the date back to which the coverage will be rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Premium paid for such services. If your coverage is rescinded we will make an equitable adjustment of Premium to your University, taking into account benefits that may have been paid. Please see your University concerning any refund to which you may be entitled.

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone 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.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the University, you may cancel your coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Benefits After Termination Of Coverage

If you are an inpatient on the date your group cancels coverage with Anthem BCBS and you have care after the date your group coverage ends and your group has replacement coverage, the replacement carrier pays primary benefits for the inpatient care provided after the effective date and this Plan pays secondary benefits. If there is no replacement carrier, this Plan pays primary benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any contract maximums, when you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first.

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Group's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

1. The date you cease to be Totally Disabled;
2. The end of a period of 12 months in a row that follows the Group termination date;
3. The date you become eligible for regular coverage under another health plan; or
4. The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability and in no event will include benefits for any dental condition.

General Provisions

Assignment of Benefits

The benefits and rights you have under your contract with Anthem cannot be assigned by you by signing a form, by operation of law or by any other manner unless you get prior permission from Anthem in writing. The insured may assign benefits for care to the Provider of the care. An assignment of benefits does not affect or limit the payment of benefits otherwise payable under the Plan.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-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 pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-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 In-Network Providers for coordination of Member care. In some instances, In-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 In-network Providers to us under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the University or us.

Comparable Health Care Services

Prices for the same medical services can vary greatly. Your health plan may offer an incentive to shop for low-cost, high-quality health care services, including Comparable Health Care Services, from participating providers. “Comparable Health Care Service” means certain non-emergency, outpatient health care services in the following categories:

- Physical and occupational therapy services;
- Radiology and imaging services
- Laboratory services; and
- Infusion therapy services

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The University, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the University and us, Anthem Health Plans of Maine, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Maine. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries.

Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The University, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Health Plans of Maine, Inc. and that no person, entity, or organization other than Anthem shall be held accountable or liable to the University for any of Anthem's obligations to the University created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the University Contract is issued will apply unless otherwise stated herein.

This Booklet, the University Contract, the University application, any riders, endorsements or attachments, and the individual applications of the Student and Dependents constitute the entire Contract between the University and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the University and any and all statements made to the University by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet. The statements you make on your application for coverage with us are representations and not warranties.

Examination of Insured

To ensure that all claims are valid, we may require the Member to have a physical or mental examination at our expense. We reserve the right to request an autopsy at our expense.

Form or Content of Booklet

No statement made by the application for insurance shall avoid the insurance or reduce benefits unless contained in the written application signed by the applicant. No agent or employee of ours is authorized to change the form or content of this Booklet or to waive any of its provisions. No change in the policy shall be valid unless approved by an officer of Anthem and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and Anthem.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem 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 / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem'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 Anthem'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.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Parts B and/or D, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the University to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the University and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the University about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We may pay In-network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by In-Network Providers to us under the Program(s).

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, at our option, to introduce or terminate from time to time, pilot or test programs for disease management, care management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives includes, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (University-Member-Anthem)

The University is responsible for passing information to you. For example, if we give notice to the University, it is the University's responsibility to pass that information to you. The University is also responsible for passing eligibility data to us in a timely manner. If the University does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

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 adjustment to claims consistent with state law. 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 impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. We have provided the reason for the retrospective denial in writing to the provider; and
B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:
    (1) The claim was submitted fraudulently;
    (2) The claim payment was incorrect because the provider or the member was already paid for health care services identified in the claim;
    (3) The health care services identified in the claim were not delivered by the provider;
    (4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;
    (5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or
    (6) The claim payment is subject to legal action.

For purposes of this subsection, 'retrospective denial of a previously paid claim' means any attempt by us to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payment or reducing or affecting the future claim payments to the provider in any other manner.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract 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.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

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 timeframe. 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 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.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your University to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your University has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a University may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you

receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Applied Behavior Analysis

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

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Autism Spectrum Disorder

Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your University's effective or renewal date and lasts for 12 months. (See your University for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by the FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the University Contract with your University, and is also subject to the terms of the Group Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Capitation

“Capitation" means a set dollar payment per patient per unit of time, usually per month, that a carrier pays a health care practitioner, institutional provider or downstream entity to cover a specified set of services and administrative costs without regard to the actual number or nature of services provided. The services covered may include the downstream entity's own services, referral services or all medical services.

Clinical Peer

“Clinical peer” means a physician or other licensed health care practitioner who holds a nonrestricted license in a state in 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

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the Schedule of Benefits for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the Schedule of Benefits for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "
Benefits After Termination Of Coverage."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the Schedule of Benefits for details.

Dentally Necessary Orthodontic Care

A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the 'Dentally Necessary Orthodontic Care' benefit description in the "What's Covered" section of this booklet for more information.

Designated Pharmacy Provider

An In-Network Pharmacy has executed a Designed Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Disability

Disability "Partial Disability" or "Partially Disabled" means that as a result of an injury or sickness, you are unable to perform one or more, but not all, of the material and substantial duties of employment or occupation; or in relation to a percentage of time worked, to a specified number of hours worked, or to compensation earned.

"Total Disability" or "Totally Disabled" means that as a result of an injury or sickness, you are unable to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. It includes conditions where you are confined to a Hospital or are completely incapacitated and unable to perform normal activities of daily living. We may require your Physician to send us proof of your condition.

Doctor

See the definition of "Physician."

Domestic Partner A person of the same or opposite sex as the subscriber, neither of whom is married to another person, who can demonstrate shared financial obligations, shared primary residence, and shared responsibility for the welfare of the subscriber.

Early Intervention Services

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

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

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.

The term “stabilize” means, with respect to an Emergency Medical Condition:
To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility.

Emergency Care

Please see the "What’s Covered" section.

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.

Enrollment Date

The first day you are covered under the Plan or, if the University imposes a waiting period, the first day of your waiting period. Should the University choose to impose a waiting period, it will not exceed 90 days.

Excluded Services (Exclusion)

Health care services your Plan doesn’t cover.

Experimental or Investigational (Experimental / Investigational)

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be Experimental or Investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

(a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

(i) cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency and such final approval has not been granted; or

(ii) has been determined by the FDA to be contraindicated for the specific use; or

(iii) is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or

(iv) is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or

(v) is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

(b) Any Service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem. In determining whether a Service is Experimental or Investigational, Anthem will consider the information described in subsection (c) and assess the following:

(i) whether the scientific evidence is conclusory concerning the effect of the Service on health outcomes;

(ii) whether the evidence demonstrates the Service improves the net health outcomes of the total population for whom the Service might be proposed by producing beneficial effects that outweigh any harmful effects;

(iii) whether the evidence demonstrates the Service has been shown to be as beneficial for the total population for whom the Service might be proposed as any established alternatives; and

(iv) whether the evidence demonstrates the Service has been shown to improve the net health outcomes of the total population for whom the Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:

(i) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

(ii) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

(iii) documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(iv) documents of an IRB or other similar body performing substantially the same function; or

(v) consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying

substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vi) the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vii) medical records; or

(viii) the opinions of consulting providers and other experts in the field.

(d) Anthem identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

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 Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable or meet specific rules set by us.

Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that the 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 Name Drug.

Group Contract (or Contract)

The Contract between us, Anthem BCBS and the University (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the University. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by The Joint Commission.

The term Hospital 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
7. Subacute care

Identification Card

The card we give you that shows your Member identification, Group Plan numbers, and the plan you have.

Inborn Error of Metabolism

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

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week..

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Maintenance Medications

Please see the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90 day supply of Maintenance Medication

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medically Necessary Health Care

- 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.

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a physician’s office or the home setting.

Member

People, including the Student and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Pocket Limit

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, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the Schedule of Benefits for details.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

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 and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List 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. Anthem's PBM in consultation with Anthem 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.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan and Plan Year

The benefit plan your University has purchased, which is described in this Booklet. The Plan Year means the period of time by which the University renews its Group Contract with us.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Premium

The amount that you must pay to be covered by this Plan. This may be based on your age and will depend on the University's Contract with us.

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) 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 the following:

1) Compounded (combination) medications, when all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense and are not essentially the same as an FDA-approved product from a drug manufacturer.
2) Insulin, diabetic supplies, and syringes.

Prescription Order

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

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, obstetricians & gynecologists, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

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 Booklet. Provider does not include a Student Health Center or University Health Services provider. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card. Examples of Providers include, but are not limited to: Clinical professional counselors, dentists, essential health care providers (rural health clinics) and essential community providers, registered nurse first assistants, social workers, certified nurse midwives, independent dental hygienists, naturopathic doctors, and psychiatric nurses.

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Referral

Please see the "How Your Plan Works" section for details.

Residential Treatment Center / Facility:

A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) 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 Health Clinic

A free-standing center providing episodic health services without appointments for diagnosis; care; and treatment.

These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

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.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor 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 Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Student

A student who is eligible for and has enrolled in the Plan according to the rules stated under the "Eligibility and Enrollment – Adding Members" section.

Telehealth

The mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management ad self-management of a patient's physical and mental health.

Treatment of Autism Spectrum Disorders

The following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) 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 eligible for coverage, 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;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

University or School

The educational institution which has a Group Contract with Anthem Blue Cross and Blue Shield, and which sponsors this Plan.

Urgent Care / Walk-In 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.