The University of Maine System
Point of Service Plan

Benefit Booklet

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Plan Name: The University of Maine System Group Health Plan

Type of Plan: Self-funded Group Health Plan, medical benefits including prescription drug benefits

Employer/Plan Sponsor Name, Address and Phone Number: University of Maine System
16 Central Street
Bangor, Maine 04401

Plan Year: January 1 though December 31, 2011

Plan Administrator: University of Maine System
16 Central Street
Bangor, Maine 04401

The Plan Administrator has authority to control and manage the operation and administration of the Plan, subject to the terms of the contracts.

Agent for Service of Legal Process: University of Maine System
16 Central Street
Bangor, Maine 04401

Type of Plan Administration: Contract Administration

Claims Administrator Fiduciary for Appeals Only: Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, ME 04106

Plan Changes or Termination: The Plan Administrator may amend the Plan in whole or in part at any time. The Plan Sponsor reserves the right to terminate the Plan at any time, by action of the University of Maine System or its delegate.
Introduction

This Document is your Benefit Booklet and describes the benefits available to participants under the self-funded University of Maine System Point of Service Choice Plan.

The benefits described in this Document are those in effect as of January 1, 2011. The Plan is subject to the terms, provisions and limitations stated herein. Every attempt has been made to be informative about benefits available under the Plan and those areas where a benefit may be lost or denied.

In the event where a question arises as to a claim for benefits or denial of a claim for benefits, the Employer, Plan Administrator, Contract Administrator, and such other individuals as may be party to or associated with the Plan shall be guided solely by this Document.

The Plan Administrator shall have authority, subject to applicable law, to interpret this Plan, its provisions and regulations with regard to eligibility, coverage, benefit entitlement, benefit determination and general administrative matters. The Plan Administrator’s decisions will be binding on all Participants and conclusive on all questions of coverage under this Plan, subject to the Participant’s appeal rights described later in the Document.

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Important
This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the University of Maine System which is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

You may be required to share in the cost for Health Plan coverage on a contributory basis. The University of Maine System shall from time to time evaluate the cost of the Plan and determine the premium to be paid for Plan benefits. The University of Maine System pays claims otherwise allowable under the terms of the Plan.
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Claims Information
For questions about covered services or claims, please call a Customer Service Representative at the number on your ID card. Be sure to have your identification number ready when you call so we can answer your questions promptly.

Anthem Blue Cross and Blue Shield has offices at the following locations:

South Portland (Main Office)
2 Gannett Drive
South Portland, ME  04106-6911
Telephone: 1-800-527-7706 or 207-822-8282

Bangor
1 Merchants Plaza
Bangor, ME  04401
Telephone:  207-561-2262

Augusta
168 Capital Street
Augusta, ME  04330
Telephone:  207-629-2238

You may also contact Anthem BCBS by e-mail at:  www.anthem.com
Section One
Eligibility, Termination and Continuation of Coverage

Eligibility

Beginning Coverage
Before your coverage begins the Contract Administrator must accept the University's group application, your application, and payment for your coverage. The University/Contract Holder acts as your remitting agent and is responsible for sending the Contract Administrator all applications and payments for coverage, as well as notifying the subscriber of any changes in payroll deductions for coverage, rate changes, changes in this contract or in any documents that comprise the contract, or termination of the contract or your coverage under the contract.

Paying Subscription Charges/Administrative Fees
Coverage is provided as stated in the Administrative Services 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 Administrative Services Agreement.
Payment for subscription charges is due the first day of each month. Anthem reserves the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

Enrolling in this Plan
When you become eligible for this Plan, you are required to complete an enrollment form to enroll yourself and your dependents. Enrollment forms are available at your University Human Resources or Campus Benefits Office.

Participation in this Plan is voluntary. Should you elect not to participate when you first become eligible, you must sign a waiver declining medical benefits.

It is important to note that if you decide to enroll at a later date, you may do so only during the Annual Enrollment Period unless you have a qualified change in employment or family status.

You may have a newly eligible dependent because of marriage, domestic partnership, birth, adoption or another reason. In order for coverage to be effective for a newly eligible dependent, you must complete a change form, which is available at your Human Resources or Campus Benefits Office.

Who is an Eligible Group Participant?
Subscribers
Except as provided for continuation members, only eligible employees, retirees or surviving spouses can apply to enroll in the Plan as subscribers.

The eligible subscriber is:
- A full-time regular employee (usually working 40 hours per week);
- A part-time regular employee working at least 50% of full-time;
- An eligible part-time faculty member (see collective bargaining agreement for eligibility requirements);
- A participant in the University Partial/Phased Retirement Program;
- A part-time regular employee with the equivalent of at least five years of full-time continuous University service. For example, ten years of half-time service equals five years of full-time service;
- A former covered employee who is eligible for long term disability benefits and is under age 65;
- A foreign visiting faculty member in the University of Maine Exchange Program;
- An eligible retiree who is under age 65; or
• If under age 65, a surviving spouse of a deceased subscriber.

Dependents
Except as provided for continuation members, only eligible dependents can be enrolled by the subscriber as covered dependents. Proof of dependency may be required. A dependent is eligible to enroll (or re-enroll if applicable) in this plan if he or she meets one of the eligibility requirements below.

The eligible dependent is:
• The subscriber's lawful spouse (provided you are not legally separated).
• The subscriber's domestic partner who meets the University's criteria and files a University Affidavit of Domestic Partnership.
• The subscriber's children (biological, adopted or stepchildren) who are:
  − Under age 26;
  − Under age 26, living with the subscriber's former spouse and who was enrolled as a dependent in the Plan before the divorce.
• A visiting foreign student who is under age 26, living with the subscriber in a parent-child relationship and 50% or more dependent on the subscriber for financial support.
• A child for whom the subscriber has been appointed legal guardian, living with the subscriber in a parent-child relationship
• A subscriber's grandchild under age 26, living with the subscriber in a parent-child relationship. The subscriber cannot enroll a child and grandchild at the same time under the same policy number. The eligible child or grandchild can be covered under a separate University of Maine System Point of Service policy number.
• A child for whom the subscriber has received a qualified court order to provide coverage; or
• A child 26 years of age or older and primarily supported by you, incapable of self-sustaining employment because of physical or mental handicap. The disability must have begun before the child's 26th birthday and the child must have been covered under the Plan continuously since his or her 26th birthday. You must submit proof of the child's condition within 31 days of his or her 26th birthday. We reserve the right to require ongoing proof of the mental or physical incapacity.
• A surviving dependent of a deceased employee if the surviving dependent was enrolled in the Plan at the time of the employee's death.

The term child includes:
• A biological child;
• A legally adopted child from the date of placement in the home or from birth, provided that a written agreement to adopt the child has been entered into prior to the child's birth. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply;
• A child for whom you are the court-appointed legal guardian; and
• A stepchild who lives with you.

Anyone who is covered under the Plan as an employee may not be a covered dependent of another employee. Your dependent child who is eligible for employee health coverage under this Plan or another group health plan is not eligible for coverage as your dependent under this Plan. If you or your spouse or domestic partner are each eligible for benefits as employees under a University health plan, only one of you can cover your dependent children.

Please note: Spouses of married dependent children are not eligible for coverage.

The eligible subscriber and dependents are not required to live or work in the service area.
Qualified Medical Child Support Order
If a qualified medical child support order is issued for your child, that child will be eligible for medical coverage as stated in the order. A qualified medical child support order is a judgment, decree, or order issued by a court of law which:

• Specifies your name and last known address;
• Specifies the child’s name and last known address;
• Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
• States the period of time to which it applies; and
• Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

Effective Date of Coverage
Coverage is effective on the first day you become eligible, as long as your enrollment application is received within 31 days of that date. Eligible dependents enrolled at the same time as the subscriber will have the same effective date as the subscriber. If you do not enroll yourself, or eligible dependents, when you are first eligible, you may enroll at a later date under the certain conditions described later in this section.

Your Share of the Cost of the Plan
To be covered under the University of Maine System Point of Service Plan, you must make contributions towards the cost of coverage.

Plan Year
Your benefits are in effect for a one-year period as long as you remain eligible and enrolled. This is often referred to as the Plan Year. The plan year begins on January 1 and ends on December 31.

Annual Late Enrollee Enrollment Period
Each year there will be an enrollment period. During this time you will be asked to review your benefit needs, add or delete covered dependents, and elect your benefits for the upcoming plan year. If you choose to make any benefit changes, they will become effective on January 1 of the upcoming year. If you choose to cover your eligible dependents, they will be covered under the same health plan you elect for yourself. If you decline benefits for yourself and/or your dependents, you will not be able to elect coverage again until the next annual enrollment period unless you have a qualified change in your family status or employment.

Late Enrollee
A subscriber or a dependent family member who requests enrollment under this group health plan following the initial enrollment period provided under the terms of the plan; or a subscriber or dependent family member who enrolls after 31 days following any of the life events described below. A late enrollee may only submit an application during the annual late enrollee enrollment period.

Qualifying Life Events
After initial eligibility, applications may also be submitted within 31 days of certain qualifying life events. Ineligibility caused by fraud or misrepresentation does not qualify. Qualifying life events include:

• Marriage;
• Divorce or legal separation;
• Formalization or dissolution of domestic partner relationship;
• Death of a spouse, domestic partner or dependent child;
• Birth, adoption, or placement for adoption;
• Termination or commencement of spouse’s employment;
• Change in employment of the subscriber, spouse, from full-time to part-time status or part-time to full-time status;
• The taking of an unpaid leave of absence by the subscriber or his/her spouse;
• Termination of the group contract;
• A court order requires that coverage be provided for the subscriber’s spouse or the minor child of the subscriber or the subscriber’s spouse;
• A court order is issued changing custody of a child. The effective date of coverage is the date of the court order;
• You have exhausted your Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits;
• A dependent satisfying or ceasing to satisfy the requirements for unmarried dependents;
• Loss of Medicaid;
• A dependent with other coverage losing that coverage;
• Reaching a lifetime limit on all benefits under another carrier’s coverage.

For coverage to begin, you must complete and submit an enrollment form which is available from your University Human Resources or Campus Benefits Office. If you are adding a family member to your coverage, unless otherwise noted above, coverage will be effective on the first day of the month following the occurrence provided Anthem BCBS receives an enrollment form within 31 days of eligibility and any applicable subscription charges are paid.

Special Enrollment

If you decline coverage for yourself or your dependents (including your spouse) because you and your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents, provided you meet each of the applicable conditions outlined below, and you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.

Conditions required for enrollment:
1. The employee has declined enrollment in writing stating that coverage under other health insurance coverage was the reason for declining coverage;
2. When the employee declined enrollment in employee and/or dependent coverage, the employee and/or dependent had COBRA continuation coverage under other health insurance and COBRA continuation coverage under that other insurer has since been exhausted; or
3. If the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
   a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
   b. employer contributions towards the other coverage have been terminated;
   c. loss of coverage under the Cub Care program;
   d. the member no longer resides in such coverage’s permitted service area provided that no other coverage under the plan is available to the member;
   e. benefits are no longer offered to a class of similarity situated individuals. For example, if a Plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the Plan continues to provide coverage to other employees;
   f. the application of the lifetime maximum benefit through another carrier’s coverage;
   g. a dependent loses eligible dependent status. An employee who is already enrolled in a benefit option may enroll in another option under the Plan due to a dependent losing eligible dependent status; or
   h. a dependent who has other coverage loses eligibility under that coverage.

You are not required to elect and exhaust COBRA coverage under another plan to enroll in this Plan during a special enrollment period. If you do elect COBRA coverage under another plan, however, you must exhaust your COBRA coverage under that plan before you can elect to participate in this Plan. Special
enrollment rights do not apply if you lose other coverage because you failed to pay the COBRA premiums.

Under the Children’s Health Insurance Program Reauthorization Act of 2009, effective April 1, 2009, two new special enrollment opportunities to elect coverage have been created under your group health plan. These are in addition to the special enrollment opportunities already described in your benefit plan documents:

A special enrollment period of 60 days will be allowed under two additional circumstances:

- If your or your eligible dependent’s coverage under Medicaid or the state Children’s Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility; or
- If you or your eligible dependent become eligible for premium assistance under a state Medicaid or SCHIP plan.

Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/SCHIP coverage or of the determination of eligibility for premium assistance under Medicaid/SCHIP.

**Return From Military Service**

If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family Members can reenroll in the Plan, provided you apply for reemployment within the timeframe permitted under the Uniformed Services Employment and Reemployment Rights Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage is effective on the effective date of your reemployment.

**Continuation of Coverage Due To Military Service**

In the event you are no longer actively at work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Military service means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Plan and upon payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this plan shall be the lesser of:

- The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) may be reinstated under this Benefit Booklet.

**Effect of Medicare on Eligibility**

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) requires employers to offer currently employed workers and their spouses, or domestic partners, who are age 65 and older the same health
care coverage offered to younger workers. If you are a person affected by TEFRA, you must elect whether or not you want to be covered under the University of Maine System Point of Service Plan. If you elect this Plan, this Plan will provide benefits before Medicare provides benefits.

If you elect to be covered under the University of Maine System Point of Service Plan, you and your lawful spouse or domestic partner age 65 or older will be eligible for all of the coverage under this Plan. If you and your lawful spouse or domestic partner are enrolled in Medicare, Medicare will pay certain benefits in addition to your group health benefits.

Even though benefit payments will be made to you under the Plan before it is determined whether any payments are to be made under Medicare, it may be to your advantage to enroll yourself and your lawful spouse or domestic partner in both Medicare Part A and Medicare Part B when first becoming eligible for Medicare. Under Medicare, premium payments may be increased for late enrollees and the date of coverage could be delayed.

Eligibility for benefits as described above is in effect from the first day of the calendar month in which you attain age 65, but only while you remain employed by the University.

**Termination of Coverage**

The subscriber, the University, or Anthem can cause your coverage to end. If your coverage ends for any reason except misrepresentation, fraud or nonpayment, it will end on the first day following the grace period (see “Paying Subscription Charges” earlier in this section for additional information). If termination of coverage is requested before the completion of the period for which Anthem has accepted payment, payment may not be refunded, and coverage may continue until the end of that period. Anthem reserves the right to take necessary action to collect premiums for the grace period.

**Cancellation of the Group Contract**

By Notice The University may cancel this contract by giving us prior written notice, as described in the group contract. It is the responsibility of the University to notify the subscriber of change in Contract Administrators. All rights to benefits under this contract end on the date of cancellation.

For Non-Payment If the University fails to pay the subscription charge, Anthem may cancel the contract. If the group contract is canceled for non-payment, Anthem will notify the subscriber of the cancellation prior to the termination date of the contract. Anthem will not notify the subscriber of cancellation if the group provides notice to us that coverage has been replaced. Your coverage will continue in force for a grace period of 31 days from the date group payment is due for the subscription charge.

Non-Renewal The University may cancel the contract by not renewing the group contract with Anthem. Anthem may cancel the contract by not renewing the group contract as described in the group agreement.

Other Cancellation Events We may cancel the group’s contract if the group gives us fraudulent information, if the group does not meet our participation or contribution requirements, or if the group moves outside of the geographic area we serve.

**Cancellation of the Participant’s Contract**

Ending Employment or Eligibility If the subscriber ends employment or membership, or if you cease to meet the definition of eligible, as described in this section, your coverage will be canceled. Your coverage will end on the last day of the month in which your employment ends. We reserve the right to verify your initial and continued eligibility.
Deletion from Membership If the University notifies us that you have been deleted from membership, your coverage will be canceled. The subscriber must delete a Participant from coverage if the Participant is no longer eligible for reasons such as a child’s marriage, the subscriber’s divorce or legal separation, termination of a domestic partnership, or a Participant’s death. The subscriber must notify the University of these events and complete a form to remove a Participant. If you do not promptly disenroll your dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and for which benefits have been paid after they were no longer eligible.

Covered Children Your coverage will be canceled if you are a covered child and:
• You reach age 26. Coverage will end on the first day of the month that occurs immediately on or after your 26th birthday.
• You cease to meet the definition of an eligible dependent.

Coverage Under Two or More Contracts If you enroll under another University health plan, your coverage under the University of Maine System Point of Service Plan will end when the alternate plan coverage begins.

Medicare is the Primary Payor If Medicare is the primary payor for any Participant covered under your contract, you are no longer eligible for the University of Maine System Point of Service Plan. You can enroll in the University comprehensive group health plan.

Non-Payment of Charges Your contract will be canceled for your group’s non-payment of subscription charges.

Misrepresentation or Fraud If you make any intentional misrepresentation, intentional omission, or use fraudulent means to continue coverage when you no longer meet the eligibility requirements, your contract will be canceled as of the last date of eligibility. Any claims incurred after the date of eligibility for which we are unable to recover payment from the provider will be the responsibility of the subscriber.

Notice of Cancellation If your coverage is canceled for non-payment of subscription charges or other lapse or default, we will send you a notice of cancellation. We will offer you the opportunity to reinstate your coverage as set forth below. The charges will be the same amount they would have been if the contract had remained in force. Please refer to the Group Continuation Coverage section, below, for information regarding cancellation of COBRA coverage.

You have the right to designate another person to receive notice of cancellation of this contract for non-payment of charges or other lapse or default. We will send the notice to you and the person you designate at the last addresses you provided to us. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form from your group or by contacting us.

Right to Reinstatement You may be eligible to reinstate the contract within 90 days after the date of cancellation if non-payment of charges or other lapse or default took place because you suffered from organic brain disease at the time of cancellation. For the purposes of this provision, organic brain disease means a mental or nervous disorder of demonstrable origin that causes significant cognitive impairment.

If you request reinstatement, we may require a physician examination at your own expense or request medical records that confirm you suffered from organic brain disease at the time of cancellation. If we accept the proof, we will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the contract had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before we can reinstate
your contract, you must pay the amount due from the date of cancellation through the month in which we bill you. The charges will be the same amount they would have been if the contract had remained in force.

If we deny your request for reinstatement, we will send you a Notice of Denial. You have the right to an appeal.

**Certificate of Creditable Coverage** When your medical coverage ends, Anthem BCBS will give you a written record of the coverage you received under the contract, under COBRA, if applicable, and the waiting period, if any. You will receive a certificate of creditable coverage when your group coverage ends, when COBRA continuation coverage terminates and upon your request (if the request is made within 24 months following either termination of coverage). If you obtain future employment, you may need to submit the certificate of creditable coverage to that employer and it may reduce the duration of your subsequent employer’s pre-existing condition limit, if there is one, by one day for each day of prior coverage (subject to certain requirements). If you are purchasing individual (non-group) coverage you may need to present the certificate of creditable coverage at that time as well.
Continuation Coverage Rights Under COBRA

Overview

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

The Plan Administrator is:

University of Maine System
16 Central Street
Bangor, ME 04401
Telephone: 207-973-3379
Attention: Director of Employee Benefits

COBRA continuation coverage for the Plan is administered by:

Benefit Concepts
20 Risho Avenue
East Providence, RI 02914
Telephone: 401-438-7100

COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who was covered under the Plan on the day before the qualifying event and will lose coverage under the Plan due to this qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage is also eligible to become a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of their premiums under this Plan plus a 2% administrative fee for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.
If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;
3. The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a “dependent child.”

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator at the address provided at the beginning of this section.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.
Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time before or during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. If you are an active employee at the date of disability, this notice along with documentation of the Social Security Administration determination should be sent to the Plan Administrator, University of Maine Systems. If you are on COBRA at the date of disability, this notice along with documentation of the Social Security Administration determination must be sent to the Plan Administrator for COBRA continuation coverage, Benefits Concepts.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event that results in a loss of coverage while receiving COBRA continuation coverage, the spouse and dependent children, if any, in your family may receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child and loses coverage. In all of these cases, you must make sure that the Plan Administrator for the COBRA continuation coverage (Benefit Concepts) is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice along with supporting documentation, such as divorce decrees, legal separation documents, and proof that a child is no longer a dependent under the plan, must be sent to the Plan Administrator for COBRA continuation coverage (Benefit Concepts) at the address provided at the beginning of this section. If you do not notify Benefit Concepts within the 60-day period, then rights to continue health insurance end.

If you are eligible for coverage under the University of Maine System's health flexible spending account, coverage will continue only for the remainder of the Plan Year in which your qualifying event occurred.

Termination of Coverage

Coverage may be terminated before COBRA eligibility period ends under the following circumstances:

Termination of all health plans provided to any employee;
1. The covered person fails to pay required contribution by the payment due date;
2. The covered person obtains coverage under another group health plan upon employment or remarriage after having elected COBRA continuation coverage, unless the new coverage contains a pre-existing clause which would affect the COBRA beneficiary; or
3. The covered person becomes entitled to Medicare benefits after having elected COBRA coverage.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator at the address provided at the beginning of this section or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s web site at www.dol.gov/ebsa.
Keep Your Plan Informed of Address Changes
In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Temporary Layoff and Temporary Leave of Absence
If the subscriber is on approved temporary layoff, coverage may continue under the group plan for up to 12 months, at the subscriber's expense. If the subscriber is on approved temporary leave of absence, coverage may continue for up to four years, at the subscriber's expense.

Long Term Disability
If you apply and are approved for long term disability benefits, you may continue coverage under the group plan for the duration of the disability or until you reach age 65, whichever comes first. You are responsible for paying applicable premium.

Retirees Who are Under Age 65
If you retire from the University before you reach age 65, you may continue in the Plan up to the age of 65 by paying the applicable premium.
Section Two
Your Primary Care Physician

Choosing Your Primary Care Physician (PCP)
Each family member must choose a primary care physician from the Contract Administrator’s directory of network professionals. Family members can choose the same primary care physician or different ones. Participants should choose a primary care physician within 30 minutes travel time of the Participant’s place of residence or employment. A Directory of PCPs is available on the Contract Administrator’s website at www.anthem.com or by calling the Customer Service Department at the number on your ID card.

To receive maximum benefits for covered services, you must follow the terms of the Plan, including, if applicable, receipt of care from your primary care physician, use of in-network providers, and obtaining any required prior authorization. Regardless of medical necessity, no benefits will be provided for care that is not a covered service even if performed by your PCP or authorized as a referral service.

If services are authorized or provided by your primary care physician, you will receive the higher level of benefits. If you choose to self-refer, most covered services will be reimbursed at the lower level shown on your Benefit Summary. Whether or not you choose to use your primary care physician, you must choose a primary care physician at the time of enrollment.

We recognize the following as primary care physicians:

Family Practitioner A family practitioner is a physician who specializes in the primary health care of people of all ages. Some family practitioners also provide maternity and general surgical care.

Pediatrician A pediatrician is a physician who specializes in the primary health care of infants, children, and adolescents. Some pediatricians also treat young adults.

Internist An internist is a physician who specializes in the primary health care of young adults and adults. Some internists also treat adolescents.

Obstetrician/Gynecologist (OB/GYN) An OB/GYN is a physician who specializes in women’s reproductive health and childbearing. In order to be a primary care physician an OB/GYN must meet certain requirements, and agree to provide all primary care.

Qualified Certified Nurse Practitioners or other qualified primary care providers, as required by law, for services within the scope of their license.

It is important for you to consider the specialty and location of your primary care physician when choosing.

Responsibilities of Your Primary Care Physician
Your PCP provides and coordinates your overall health care. When you need medical services, contact your PCP. He or she will usually provide the care, such as routine physical examinations, treatment of sickness or injury and administration of medically necessary injections and immunizations. When your PCP determines that you need specialized care, he or she will refer you to a network specialist or coordinate any hospital care you may need.
Changing Your Primary Care Physician

If you or a dependent wish to change PCPs, you may call the Contract Administrator to obtain a change form. You may also change your PCP over the telephone by calling a Customer Service Representative at the telephone number on your ID card.

When you change PCPs, the change is effective on the first day of the month after: 1) your change form is received and accepted; or 2) you call to request the change. Referrals from your former PCP are not valid. You should discuss the referrals with your new PCP.

If your primary care physician’s participation in this network ends, Anthem will notify you and will furnish you with a list of primary care physicians so you can choose a new one. If you do not choose a new primary care physician within the specified time, Anthem may assign a primary care physician of the same specialty (if available) for you. If your primary care physician unexpectedly withdraws from the network, you may be assigned a temporary primary care physician until you choose a new one.

Continuity of Care

If you are undergoing a course of treatment and the treating provider or professional withdraws from this network, Anthem will notify you of the termination. You may be allowed to continue receiving care from the withdrawing provider or professional for a period of 60 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 or professional:

- 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.

Referrals

Your group health plan provides extensive benefits when health care services are provided or coordinated by your primary care physician. You will receive most of your health care services from your primary care physician. If your primary care physician determines that you need specialized care, he or she will authorize you to receive health care services from another health care professional or provider. A referral from your primary care physician is not a guarantee of coverage for those services. The service must also be covered within the terms of this contract. Thus, regardless of medical necessity, no benefits will be provided for care that is not a covered service, even if performed by your PCP or authorized as a referral service. You may call a Customer Service Representative at the number on your ID card to determine if the service is a covered service.

If your primary care physician authorizes a referral to a professional or provider, make sure you understand:

- The name of the professional or provider to whom you are being referred.
- The period of time, the number of visits and services for which care is authorized.
- Who is to make the appointment(s) with that professional or provider - you or your primary care physician’s office staff.

You will need to discuss additional care recommended by the referring professional or provider with your primary care physician, if the care exceeds the initial referral for services.

If your referred professional or provider recommends you to another professional or provider, you must contact your primary care physician prior to any treatment so he or she can determine if that care will be authorized. Only your primary care physician can authorize care with another professional or provider.
If your primary care physician authorizes these services, benefits will be provided according to the terms of this contract. Care that is not authorized by your primary care physician may be paid at the reduced benefit level.

For payment at the higher benefit level, referrals for mental health and substance abuse treatment services must be obtained through Anthem’s behavioral health care manager. You do not need a referral from your primary care physician. Please refer to the “Utilization Management” section of this Benefit Booklet for details.

**Note:** If your primary care physician determines you do not need a referral and you disagree, you have the right to appeal the decision, as outlined in the “Complaints and Appeals” section of this Benefit Booklet.

**Referrals to Specialists**
Your primary care physician may refer you to a specialist. Specialists are professionals who practice in specialty areas such as dermatology, neurology, surgery, and others. With the prior authorization of your primary care physician, you can obtain care from network specialists. To obtain the higher level of benefits, you must be referred by your primary care physician.

You may receive eye care services from an in-network eye care provider without obtaining a referral from your primary care physician for a maximum of two visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care. See the “Covered Services” section, subsection “Eye Care Services” for information about this benefit.

**Referral to Non-Participating Providers and Professionals**
You may require services that are not available from professionals or providers within the network. Your primary care physician may make a referral to a non-network provider or professional. Referrals to a non-network provider or professional must be approved by the Contract Administrator for services to be reimbursed at the primary care physician benefit level.

**Self-Referrals**
The amount of your benefits is determined each time you seek health care services. To receive the higher level of benefits provided by this Plan, your primary care physician must either provide or arrange for your necessary health care services, unless otherwise stated. However, you do have the choice to self-refer for covered health care services or supplies whenever you feel it is necessary. In most cases, your benefits will be provided at a lower level of coverage and you may be responsible for any remaining balances above the Maximum Allowance. This level of benefits is referred to as your Self-Referred Level of Benefits on your Benefit Summary. Benefits are not available for certain self-referred services. Please see your Benefit Summary for details.

**Standing Referrals**
A Participant with a special condition requiring ongoing care from a specialist may receive a standing referral to a specialist for treatment of the special condition from the Participant’s PCP. A special condition is a condition or disease that is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time. A standing referral must be made according to a treatment plan, approved by our medical director in consultation with the Participant’s PCP.

**Maintaining the Patient-Physician Relationship**
Participants enroll in this Plan with the understanding that the primary care physician is responsible for determining appropriate treatment for the Participant. For personal or religious reasons, some Participants
may disagree with the treatment recommended by the primary care physician.

They may demand treatment that the primary care physician or the Contract Administrator judge to be incompatible with proper medical care. In the event of such disagreement, Participants have the right to refuse the recommendation of the primary care physician. Participants who do not adhere to recommended treatment or who use non-recognized sources of care because of such disagreement, do so with the full understanding that we have no obligation for the costs of such non-authorized care.

**Relationship of Network Providers and Professionals**
The Contract Administrator contracts with a select group, or network, of providers and professionals to provide you with health care services. These providers and professionals are not the Contract Administrator’s employees. In their agreements, network providers and professionals agree to be responsible for the health care services provided to Participants according to quality assurance and utilization management standards. Under both the terms and conditions of this Plan, and the Contract Administrator’s agreements with network providers and professionals, the Plan pays for covered services determined to be appropriate by the Contract Administrator’s utilization management standards.

**Emergency Care In or Outside of the Service Area**
This Plan provides benefits for health care services received in an emergency care facility or setting. To receive benefits for emergency care services, you must have symptoms of sufficient severity that a prudent lay person would reasonably expect that the absence of immediate medical attention could result in serious physical and/or mental jeopardy; serious impairment to body functions; or serious dysfunction to any body organ or part.

In emergency situations, you should seek immediate medical attention. The Plan covers emergency services necessary to screen and stabilize, without prior authorization from your primary care physician, only if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. You should contact your primary care physician within 48 hours of receiving emergency services, or as soon as possible after emergency screening and stabilization have taken place, for appropriate follow-up care, if needed. Benefits for emergency care may be denied if your primary care physician, applying the prudent lay person guideline, determines that your symptoms did not indicate that emergency services were necessary. If you disagree with the medical judgment of your primary care physician, and feel that your emergency services should be authorized, you have the right to appeal that decision, as outlined in the “Benefit Determinations, Payments and Appeals” section of this Benefit Booklet.

Follow-up visits and elective and routine procedures are not covered unless performed by or authorized in advance by your primary care physician.

If you are traveling outside of Maine and you need urgent care, you can call your PCP or you can call the telephone number on your ID card for direction. You will be responsible for copayments, just as you would if you received care within the network. Any follow-up care should be coordinated with your PCP once you return home.

**Participants at School Outside of Their Service Area**
If you require emergency services while you are outside your service area enrolled as a full-time student at a school or college, we will provide benefits for covered services in a physician’s office, clinic, or hospital. You should seek emergency care services just as you would at home or inside your service area.

For non-emergency care, you should seek care and send the itemized bill with a short letter of explanation to our Customer Service Department. The letter must indicate that services were for a student away at school. Follow-up visits and elective and routine procedures are not covered unless performed by or authorized in advance by your primary care physician.
Section Three
Utilization Management

All services you receive are subject to the provisions in this section. Failure to comply with any or all of the requirements listed below will result in a penalty, or in denial or reduction of your benefits. If you have any questions, please call the number on the back of your Identification Card.

If you have a health concern, please contact your primary care physician. Unless otherwise noted in this Benefit Booklet, only services that have been provided, arranged or authorized by your primary care physician and approved by us, are eligible for the higher level of benefits.

The purpose of Utilization Management is to review your medical care while you are in the hospital to determine if you are receiving medically necessary hospital services. The program includes an ongoing monitoring of your health care needs and possible assignment of a care manager to work with you and your physician to optimize your benefits.

This review is to determine financial reimbursement if the requested benefit is a covered service. The decision for treatment is solely between the patient and physician, regardless of the decision made regarding reimbursement.

None of the Contract Administrator’s employees or the providers the Contract Administrator contracts with to make medical management decisions are paid or provided incentives to deny or withhold benefits for services that are medically necessary and are otherwise covered under the Plan. In addition, the Contract Administrator requires members of the clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying benefits for services that are medically necessary and are otherwise covered under the Plan.

Anthem BCBS Medical Policy
The purpose of medical policy is to assist in the interpretation of medical necessity. However, the Benefit Booklet and the Administrative Services Agreement take precedence over medical policy. Medical technology is constantly changing and the Contract Administrator reserves the right to review and update medical policy periodically.

Prior Authorization
Some services require prior authorization before benefits will be provided. If you have any questions regarding Utilization Management or to determine which services require prior authorization, please call the number on the back of your Identification Card. Prior Authorization does NOT guarantee coverage for or payment of the service or procedure reviewed. Contact your PCP or the Contract Administrator to be sure that prior authorization has been obtained.

Participants’ Rights and Responsibilities
You have the right to:
• Request in writing a copy of the clinical review criteria used in arriving at any denial or reduction of benefits;
• Appeal any adverse determinations based on medical necessity;
• Refuse treatment for any condition, illness, or disease without jeopardizing future treatment.
Procedure for Appeal of Medical Necessity
If you disagree with the Contract Administrator’s determination of medical necessity, you have the right to appeal as outlined in the “Benefit Determinations, Payments and Appeals” section of this Benefit Booklet.

Inpatient Admission Review
Pre-Admission Review All inpatient admissions, with the exception of emergency and maternity admissions, require pre-admission review.

You or your primary care physician must call the telephone number on your ID card for review before you are admitted.

If you self-refer, it is your responsibility to make sure the call is made. If you self-refer and do not call for a pre-admission review, we may reduce benefits for the admission by as much as $500. This penalty amount does not count toward your deductible or coinsurance limit.

We will notify you and your physician of the results of the pre-admission review within 2 working days of our obtaining all necessary information regarding the proposed admission. For special rules that apply to maternity admissions, see the “Continued Inpatient Stay Review” provision in this section.

Post-Admission Review All inpatient admissions for emergency and some maternity services are subject to post-admission review. For post-admission review of an emergency admission, you, a family member, your physician, or the provider should call within 48 hours after you are admitted. For maternity post-admission review, you, a family member, your physician, or the provider should call if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. We will notify you and your physician of the results of the post-admission review within 2 working days of receiving all necessary information.

For emergency care, if you are admitted to a non-participating hospital or other non-participating health care facility, benefits are provided at the higher level only until we determine that your condition reasonably permits your transfer to a participating hospital or other participating health care facility. If you choose not to be moved once your condition permits, benefits will be provided at the lower level from that point forward.

For emergency and maternity admissions, call the telephone number on your ID card. You can call 24 hours a day, seven days a week. During non-business hours, you may be asked to leave your information on a confidential voice messaging system.

For special rules that apply to maternity admissions, see the “Continued Inpatient Stay Review” provision in this section.

Continued Inpatient Stay Review During your stay in the hospital, our registered nurses and physician advisors evaluate your progress to determine the appropriateness of the services being rendered, appropriateness of the setting, discharge planning needs and coordination of alternatives to inpatient care. If we determine that inpatient benefits are no longer approved, your attending physician will be notified immediately by telephone and you will be notified by letter that benefits will not be available beyond a certain date specified in the letter, if you are liable for the entire cost of continued care.

If you elect to continue your hospital stay after you have been notified by letter that no further inpatient days are approved, benefits for inpatient days beyond the date specified in the notification letter will be denied. You are entitled to appeal this determination as outlined in this Benefit Booklet.
Note:
**Maternity Admissions** - This contract generally may not, under federal law, restrict benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law 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). The inpatient length of stay for a maternity admission will be determined by the attending physician in consultation with the patient. In any case, this contract may not, under federal law, require authorization from us for prescribing a length of stay that does not exceed 48 hours (or 96 hours as applicable).

**Admissions for the Treatment of Breast Cancer** - The inpatient length of stay for a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer, will be determined by the attending physician in consultation with the patient.

**Discharge Planning** You may be ready to be discharged from a provider even though you still need medical care. In that case, we will work with you and your physician to make arrangements for treatment even after you are released from the provider.

**Inpatient and Outpatient Mental Health/Substance Abuse Review**
PCP authorization is not required for mental health or substance abuse services.

**Inpatient Services**
All inpatient mental health and substance abuse services, except for treatment of emergency medical conditions, require preadmission review. You must call the telephone number on your ID card for approval before you receive the services.

For benefits at the higher level, you or your representative must obtain approval for the inpatient admission and the services must be received from the provider or professional indicated by the behavioral health care manager. In an emergency, you should call within 48 hours.

If you self-refer, you or your representative must obtain approval for the inpatient admission. If you do not receive a preadmission review before you are admitted for non-emergency services, your benefits for the admission can be reduced by up to $500. If you receive services from a non-participating provider or professional, benefits will be paid at the lower level of coverage.

**Outpatient Services**
For benefits at the higher level of coverage, you or your representative must call the telephone number on your ID card for approval before you receive mental health and substance abuse services and the services must be received from the provider indicated by the behavioral health care manager.

If you self-refer and do not obtain approval before receiving services and/or do not receive services from a provider who is in the mental health and substance abuse network of providers, benefits will be paid at the lower level of coverage. In an emergency, you should call within 48 hours.
Individual Care Management
Anthem BCBS has a care management program that is tailored to the individual. The care managers work collaboratively with Participants and their families and providers to coordinate the Participant’s health care benefits.

In certain extraordinary circumstances involving intensive care management, benefits may be provided for alternate care that is not listed as a covered service. Covered services may be extended beyond the contractual benefit limits of this plan. The decision will be made case-by-case. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Participant. The Contract Administrator reserves the right, at any time, to alter or cease providing extended benefits or approving alternate care. In such case, the Contract Administrator will notify you or your representative in writing.
Section Four
Covered Services

This section, along with the “Exclusions” section, explains health care services for which benefits will and will not be provided. All benefits and Covered Services are subject to the deductibles, coinsurance, copayments, maximums, exclusions, limitations, terms, provisions and conditions of this Benefit Booklet, including any attachments and amendments or riders. The Contract Administrator’s payment for covered services will be limited by any applicable copayment, deductible, or annual or lifetime maximum. Please check your Benefit Summary for deductibles, copayments, coinsurance, maximums, and limitations that apply. Please see the “Utilization Management” section for conditions that apply to all inpatient admissions and outpatient mental health and substance abuse services.

Benefits for covered services may be payable subject to an approved treatment plan. Only medically necessary care is covered. Although the Plan does not provide benefits for covered services that do not meet the definition of medical necessity, you and your physician must decide what care is appropriate. The fact that a physician may prescribe, order, recommend or approve a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment. If you choose to receive care that is not a covered service or does not meet the definition of medical necessity, the Plan will not provide benefits for it. The Contract Administrator bases its decisions about referrals, prior authorization, medical necessity, experimental services and new technology on medical policy developed by Anthem BCBS. Anthem BCBS may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Unless specifically stated otherwise, all benefits, limitations and exclusions under this Plan apply separately to each covered family member.

A Participant’s right to benefits for covered services provided under this Benefit Booklet is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem BCBS medical policy, continued inpatient stay review, pre-admission review, post-admission review, and prior authorization. A description of each of these guidelines explaining its purpose, requirements and effects on benefits is provided in the “Utilization Management” section. Failure to follow the Utilization Management guidelines for obtaining covered services will result in reduction or denial of benefits.

Allergy Testing and Injections Benefits are provided for allergy testing and injections.

Ambulance Service Benefits are provided for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a hospital when other transportation would endanger your health.

If no hospital in your local area is equipped to provide the care you need, we will provide benefits for ambulance transportation to the nearest facility outside your area that can provide the necessary care. If you are transported to a hospital that is not the nearest hospital that can meet your needs, benefits will be based on transport to the nearest hospital that can meet your needs.

For payment at the higher benefit level, you are not required to obtain a referral from your primary care physician for ambulance services.

Ambulatory Surgery Centers Benefits are provided for certain covered services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility’s licensure.
Anesthesia Services Benefits are provided for anesthesia only if administered while a covered service is being provided, except as outlined in the “Dental Procedures” provision. We do not provide benefits for local or topical anesthesia unless it is part of a regional nerve block.

Asthma Education Benefits are provided for approved asthma education programs for our covered Participants with asthma and their families. Benefits are provided when the program is received from an approved network provider or professional. Please call the Contract Administrator for a listing of approved providers and professionals.

Autism Spectrum Disorders Benefits are provided for members who are five years of age or under 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 Benefit Summary for limits that may apply.

Blood Transfusions Benefits are provided for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

Chemotherapy Services Benefits are provided for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by the Contract Administrator for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the Contract Administrator for medically accepted indications or as required by law.

Chiropractic Care Benefits are provided for chiropractic care. You may self-refer to a licensed participating chiropractor and receive the higher level of benefits; benefits are available for up to 36 visits per calendar year. A lower level of benefits is available if you self-refer to a non-network chiropractor. No benefits are available beyond the 36 visit limit without a referral from your PCP.

Clinical Trials Benefits are provided for routine patient costs for items and services furnished in connection with participation in approved clinical trials. A Participant is eligible for coverage in an approved clinical trial if the following conditions are met:
• The Participant has a life-threatening illness for which no standard treatment is effective;
• The Participant is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;
• The Participant’s participation in the trial offers meaningful potential for significant clinical benefit; and
• The Participant’s referring physician has concluded that the Participant’s participation in the trial would be appropriate based on the above named criteria.

Routine costs do not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial or for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

An approved clinical trial means a clinical research study or clinical investigation approved and funded by
the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

**Contraceptives** Benefits are provided 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.

**Dental Procedures** Benefits are provided for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the Participant is classified as vulnerable. Examples of vulnerable Participants 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** Benefits are provided only for the following:
- Setting a jaw fracture
- Removing a tumor or cyst (but not a root cyst)
- Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting
- Removing seven or more permanent teeth;
- Gingivectomies;
- Osseous surgery
- Dental services needed as a result of chemotherapy;
- Treatment of an accidental injury to repair or replace natural teeth
- Repairing or replacing dental prostheses caused by an accidental bodily injury

In order to determine possible coverage of other dental procedures that are related to medical conditions not listed in this provision, have your dentist submit a proposed treatment plan to us.

**Diabetic Services** Benefits are provided 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 approved by us.

**Diagnostic Services** Benefits are provided for diagnostic services, including diagnostic laboratory tests and x-rays, when they are ordered by a professional to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contract.

You must receive prior authorization from us for the diagnostic services which include but are not limited to: CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.
Durable Medical Equipment and Prostheses  If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. See your Benefit Summary for limits that apply. These terms apply to the following services:

Durable Medical Equipment Benefits are provided for the rental or purchase of durable medical equipment. Whether you rent or buy the equipment, we provide benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Benefits for replacement or repair of purchased durable medical equipment are subject to our approval. We do not provide benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the durable medical equipment. Supplies for durable medical equipment are not subject to any durable medical equipment maximum applicable to this plan.

Prostheses Benefits are provided for prostheses. Prostheses include artificial limbs and prosthetic appliances. Please refer to the "Exclusions" section for additional information.

Early Intervention Services Benefits are provided 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 Benefit Summary for limits that may apply.

Emergency Room Care Benefits are provided for emergency room treatment received for medical emergencies once you pay the emergency room copayment listed on your Benefit Summary. You or a designated person should contact your physician within 48 hours from the time you receive care.

If you are admitted to the hospital from the emergency room, the emergency room copayment is waived. You or a designated person should contact your physician within 48 hours from the time you are admitted. If you do not contact your physician, you or someone you designate should call the telephone number listed on your ID card within 48 hours of admission.

Eye Care Services Benefits are provided for eye care services. Eye care services means those urgent health care services related to an examination, diagnosis, treatment, and management of conditions, illnesses, and diseases of the eye and related structures that are provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. See the “Referrals to Specialists” subsection in the “Your Primary Care Physician” section for additional information about this benefit.

Eye Examinations Benefits are provided for routine eye examinations for children ages birth to the end of the calendar year in which you reach age 19. After the end of the calendar year in which you reach age 19, coverage is limited to one examination every two calendar years. A PCP referral is not required for routine eye examinations. Eye examinations to diagnose a medical condition are covered as often as needed regardless of age, but require a referral from your PCP.

Family Planning Benefits are provided for family planning. See the “Contraceptives” provision within this section for details.
Foot Care Benefits are provided for cutting, removal or treatment of corns, calluses, or toenails only if medically necessary because of diabetes or other similar disease. Open cutting, operations of metatarsalgia or bunion, or complete removal of nail roots are covered.

Freestanding Imaging Centers Benefits are provided for diagnostic services performed by freestanding imaging centers. All services must be ordered by a professional.

Hearing Care Benefits are provided for wearable hearing aids for covered participants up to age 18. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. 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.

Home Health Care Services Benefits are provided for home health care services when services are performed and billed by a home health care agency. A home health care agency must submit a written plan of care, and then provide the services as approved by the Contract Administrator.

Benefits are provided for the following home health care services:
• Physician home and office visits;
• Registered nurse (RN) or licensed practical nurse (LPN) nursing visits;
• Services of home health aides when supervised by an RN;
• Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy, and nutritional guidance;
• Supportive services, including prescription drugs, medical and surgical supplies, and oxygen.

Hospice Care Services Benefits are provided for hospice care services furnished in your home by a home health agency to a Participant who is terminally ill and the Participant’s family. A Participant who is terminally ill means a person who has a medical prognosis that the person’s life expectancy is 12 months or less if the illness runs its normal course.

Benefits are provided for hospice care services by a home health agency up to 24 hours during each day of care. Hospice care services are provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for hospice care services, the patient need not be homebound or require skilled nursing services. Coverage for hospice care services is provided in either a home or inpatient setting.

Hospice care services include, but are not limited to: physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and durable medical equipment, occupational, physical or speech therapies, home health care services, bereavement services and volunteer services.

Hospice Respite Care Benefits are provided for up to a 48-hour period for respite care, subject to care management. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide hospice care.

Before the patient receives respite care at home, a home health agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an inpatient hospice.
**Inpatient Hospice Services**  Benefits are provided for inpatient hospice care at an acute care hospital or skilled nursing facility. The same services are covered for inpatient hospice care as are covered under inpatient hospital services.

**Inborn Errors of Metabolism**  Benefits are provided 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 Participants with diseases caused by inborn errors of metabolism.

**Independent Laboratories**  Benefits are provided for diagnostic services performed by independent laboratories. All services must be ordered by a professional.

**Infant Formula**  Benefits are provided 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**  Benefits are provided for procedures and services related to the diagnosis of infertility and to treat the cause of infertility when services are provided or authorized by your PCP. Artificial insemination is covered. All other methods of impregnation/fertility enhancement are not covered. No benefits are available for self-referred services. See the "Exclusions" section for infertility services that are not covered.

**Infusion Therapy**  We provide Benefits for infusion therapy when services are provided by a licensed professional, facility, ambulatory infusion center, or home infusion therapy provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.

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

**Inpatient Hospital Services**  Benefits are provided for the following inpatient hospital services:
- Room and board, including general nursing care, special duty nursing, and special diets;
- Use of intensive care or coronary care unit;
- Diagnostic services;
• Medical, surgical, and central supplies;
• Treatment services;
• Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, and inpatient occupational therapy, physical therapy, inhalation therapy, and radiotherapy services;
• Phase I cardiac rehabilitation;
• Medication used when you are an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law;
• Blood and blood derivatives;
• Prostheses or orthotic devices;
• Newborn care, including routine well-baby care.

Benefits for an inpatient stay in a hospital will end with the earliest of the following events:
• You are discharged as an inpatient;
• You reach any of the limits or maximums shown in your Benefit Summary;
• Your physician, hospital personnel, or we notify you that inpatient care no longer meets our guidelines for continued hospital admission.

**Manipulative Therapy** Benefits are provided for treating acute musculo-skeletal disorders. No benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions.

**Massage Therapy** - We provide Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a Covered Professional (Please see definition of Covered Professional.). A massage therapist is not a Covered Professional.

**Medical Care** Benefits are provided for medical care and services including office visits and consultations, hospital and skilled nursing facility visits, and pediatric services.

**Medical Supplies** Benefits are provided for medical supplies furnished by a provider in the course of delivering medically necessary services. This benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a physician.

**Mental Health Services - Professional** Benefits are provided for only the following mental health services when they are for the active treatment of mental disorders. These services must be part of an established plan of treatment and must be performed and independently billed by a professional acting within the scope of his or her license.

You will receive maximum benefits for mental health services when you receive care from network providers and professionals.
• Individual and group counseling;
• Family counseling;
• Psychological testing;
• Diagnostic and evaluation services;
• Emergency treatment for the sudden onset of a mental health condition requiring an immediate and acute need for treatment;
• Intervention and assessment.
The “Utilization Management” section contains additional information about seeking mental health services. Please refer to your Benefit Summary for additional information regarding mental health benefits.

**Mental Health and Substance Abuse Services - Provider** Benefits are provided for inpatient, outpatient, and day treatment services for mental health and substance abuse when you receive them from a provider. You will receive maximum benefits for mental health services when you receive care from network providers and professionals.

If you receive provider services from a community mental health center or substance abuse treatment facility, services must be:
- Supervised by a licensed physician, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

Benefits are provided for only the following mental health and/or substance abuse treatment services:
- Room and board, including general nursing;
- Prescription drugs, biologicals, and solutions administered to inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.

The “Utilization Management” section contains additional information and requirements for mental health and substance abuse services. Please refer to your Benefit Summary for additional information regarding mental health and substance abuse benefits.

**Morbid Obesity** Limited benefits are provided for 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. We do not provide benefits for weight loss medications.

**Nutritional Counseling** Benefits are provided for nutritional counseling when required for a diagnosed medical condition.

**Obstetrical Services and Newborn Care** Benefits are provided for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. Benefits for routine circumcisions are covered while the newborn is still in the hospital, or later if medically necessary. Please see the "Utilization Management" section for additional information related to maternity admissions.

**Office Visits** Benefits are provided for office visits. Office visits are subject to a copayment. Office visits include visits to a Walk In Center. Please refer to your Benefit Summary.

**Organ and Tissue Transplants** Benefits are provided for organ and tissue transplant procedures listed below. You must receive prior approval from the Plan before you are admitted for any transplant procedure. Your physician will work with the Contract Administrator’s registered nurses and physician advisors to evaluate your condition and determine the medical appropriateness of a transplant procedure. Failure to
receive approval prior to admission may result in a denial or reduction of benefits.

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

No other organ or tissue transplant is covered. The Plan will not pay any benefits for any services related to a transplant the Plan does not cover.

Benefits are provided as follows:
• If both the donor and the recipient are covered members of ours, we will provide benefits to cover both patients for organ and tissue transplants;
• If the recipient is a member under a contract with us but the donor is not, then we will provide benefits for both the recipient and donor as long as similar benefits are not available to the donor from other sources;
• If the recipient is not a member under a contract with us but the donor is a member, we will not provide benefits to either the donor or the recipient.

Orthotic Devices Benefits are provided for certain orthotic devices such as orthopedic braces, back or surgical corsets, splints, orthopedic shoes, arch supports, shoe inserts, abduction and rotation bars. The Plan does not provide benefits for other foot devices, support hose, garter belts and other supportive devices available over-the-counter or by prescription unless stated above.

Outpatient Private Duty Nursing Private duty nursing care provided outside of the hospital is covered. Care must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and ordered by a physician. You or your physician must call the number on your identification card for prior approval.

Outpatient Services Benefits are provided for the following hospital outpatient and rural health center services:
• Emergency room services/emergency care;
• Removal of sutures;
• Application or removal of a cast;
• Diagnostic services;
• Surgical services;
• Removal of impacted or unerupted teeth;
• Endoscopic procedures;
• Blood administration;
• Radiation therapy;
• Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for benefits;
• Outpatient educational programs such as asthma education and diabetes education. Please check with the Contract Administrator to see if you are eligible for benefits.

Parenteral and Enteral Therapy Benefits are provided for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Physical and Occupational Therapy Benefits are provided for short-term physical and occupational
therapy on an outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed professional acting within the scope of his/her license. Please see your Benefit Summary for limits that apply.

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

**Prescription Drugs**

**Prescription Drugs** Benefits are provided under your prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a hospital. The Covered Drug Copayment or Coinsurance may vary based on whether the Prescription Drug has been classified by Anthem as a Tier 1, Tier 2, or Tier 3 Drug.

Anthem BCBS/WellPoint, Inc. has established the WellPoint National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignment of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Anthem BCBS/WellPoint based upon clinical decisions provided by the National P & T Committee, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives, and where appropriate, certain clinical economic factors.

You may review a copy of the current tier listing online at: [www.anthem.com](http://www.anthem.com) or you may request a copy of the tier listing by calling a customer service representative at the number on the back of your ID card. The tier listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage. Refer to the prescription drug Benefit sections in this Benefit Booklet for information on coverage, limitations and exclusions.

We retain the right at Anthem BCBS/WellPoint’s discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another Tier.

- Tier 1 drugs have the lowest copayment. This tier will contain low cost and preferred medications that may be generic, single source brand drugs, or multi-source brand drugs.
- Tier 2 drugs will have a higher copayment than those in tier 1. This tier will contain preferred medications that may be generic, single source, or multi-source brand drugs.
- Tier 3 drugs will have a higher copayment than those in tier 2. This tier will contain non-preferred and high cost medications. This will include medications considered generic, single source brands, or multi-source brands.

From time to time we may initiate various programs to encourage covered persons to utilize more cost effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, OTC, or preferred products. Such programs may involve reducing or waiving copayments or coinsurance for certain drugs or preferred products for a limited period of time.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization of benefits. Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the network pharmacist is informed of the prior authorization requirement through the pharmacy’s computer system and the pharmacist is instructed to contact the pharmacy benefits manager (PBM). The PBM is a pharmacy benefit management company with which we contract to manage your pharmacy benefits. Please see the “Benefit Determinations, Payments and Appeals” section for additional information.

The PBM uses pre-approved criteria, developed by Anthem’s national Pharmacy and Therapeutics Committee and reviewed and adopted by Anthem. The PBM communicates the results of the decision to the pharmacist. The PBM
may contact your prescribing physician if additional information is required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to appeal through the appeals process outlined in the “Benefit Determinations, Payments and Appeals” section of this Benefit Booklet.

Please note one exception to the prior authorization requirement. When the prior authorization is initiated but cannot be completed, Anthem may authorize coverage for a sufficient amount of the Prescription Drug which will provide the additional time for Anthem to make the prior authorization decision.

For a list of current drugs requiring prior authorization, please contact a customer service representative at the number on the back of your ID card or consult the website at www.anthemprescription.com. The tier listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

**Continuity of Prescription Drugs**
We reserve 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.

The cost share requirements of this plan will apply. We do not provide benefits for conditions or services not otherwise covered under this Benefit Booklet.

**Prescription Drugs From A Retail Pharmacy**

When your prescription is filled at a retail Pharmacy, you pay the amount shown on your Benefit Summary. Certain participating 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 our Customer Service Department at the number on your ID card for a list of participating pharmacies.

**Prescription Drugs By Mail**
Your Contract may allow you to obtain Prescription Drugs by mail. To obtain Benefits for Prescription Drugs by mail, complete a mail order Pharmacy form, available through our Customer Services Department, and mail it with your prescription. You must pay the applicable Copayment amount indicated on your Benefit Summary.

**Changes In Your Prescription**
Your pharmacist may check your prescription to determine if there may be harmful interactions between the prescription you are filling and any other prescription you may be taking. The pharmacist may contact your Physician to discuss possible changes to your prescription.

**Refills on Prescriptions**
Your Physician will indicate the number of refills for your prescription. We will cover the refill for your prescription when you have taken 75% of the medication or within 10 days of the refill date, whichever is greater, based on the dosage schedule prescribed by the Physician. We will not provide Benefits for refills that are filled sooner.

**Maintenance Prescription Supplies**
Benefits are provided for up to a 90-day supply if prescribed by your Physician as medically appropriate. Please refer to your Benefit Summary for Copayment amounts that apply to you.

**Therapeutic Substitution of Drugs**
Your Pharmacy benefit includes a therapeutic drug substitution program approved by Anthem and managed by the PBM. This voluntary program is designed to inform Members and Physicians about tiering alternatives. The PBM may contact the Member, the Member’s representative, or the prescribing Physician to make the Member aware of tiering substitution options. Only the Member and the Member’s Physician can determine whether the therapeutic substitution is appropriate.

**Half-Tablet Program**
The Half-Tablet Program will allow Members to pay a reduced copayment on selected “once daily dosage” medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take “1/2 tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member’s decision to participate should follow...
consultation with and the concurrence of his/her Physician. To obtain a list of the products available on this program call the Customer Service number on the back of your ID card.

**Vacation Supplies**  If you are going out of the area for an extended period of time and your supply of medications is not sufficient for this period, you may contact your Pharmacy or the prescribing Physician prior to leaving the area to receive an early refill or an extended-day supply of medications while you are away from home. Controlled substances are excluded from this program.

**Specialty Pharmacy Network**  You or your physician can order specialty drugs directly from any network, specialty network or non-network pharmacy. If you or your physician orders your specialty drugs from a specialty participating pharmacy, you will be assigned a patient care coordinator who will work with you and your physician to obtain prior authorization and to coordinate any shipping of your specialty drugs directly to you or your physician’s office. Your patient care coordinator will also contact you directly when it is time to refill your specialty drug prescription.

Specialty pharmacies may fill retail and mail service specialty drug prescription orders, subject to a 30-90 day supply. The amount of benefits paid is based upon whether you receive the covered services from a network pharmacy, including a network specialty pharmacy, a non-network pharmacy, or a mail order vendor. You may obtain a list of specialty drugs available through the specialty pharmacy network and a list of participating specialty pharmacies by contacting the Anthem Customer Service number on the back of your ID card, or by visiting the website [www.anthem.com](http://www.anthem.com).

Certain Prescription Drugs are not covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem on appeal to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing for the appeal, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative. For additional information, please consult our website at [www.anthem.com](http://www.anthem.com) or contact Customer Service at the number on the back of your ID card.

**Preventive and Well-Care Services**  Benefits are provided for the following preventive and well-care services when provided by your primary care physician. Unless otherwise stated, routine care must be provided by your PCP.

- Periodic routine physical examinations;
- Well-baby care;
- Well-child care;
- Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics;
- Routine hearing examinations to determine the need for hearing correction up to the end of the calendar year in which you reach age 19. Hearing examinations to diagnose a medical condition are covered regardless of age;
- Routine pediatric and adult immunizations;
- Counseling for family planning, insertion and fitting of contraceptive devices, voluntary sterilization and reverse sterilization. Benefits are not provided for over-the-counter contraceptive devices.
- Prostate specific antigen test and digital rectal examinations for men.

The following preventive and well-care services are covered at the higher benefit level and do not have to be provided or authorized by your primary care physician:

- Routine eye examinations for vision correction. Routine eye examinations will be covered as outlined in the Eye Examinations provision of this section;
- Gynecological examinations, which include breast and pelvic examinations, and Pap smears when performed by a physician, certified nurse practitioner, or certified nurse midwife. These services must be received from a HMO Choice Point of Service network professional.
- Screening mammograms.
- Colorectal Cancer Screening (Note: diagnostic colonoscopies are considered an outpatient surgical procedure.)
Radiation Therapy Benefits are provided for radiation therapy.

1. **Reconstructive Surgeries, Procedures and Services** Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be necessary due to accidental injury; or
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary Health Care to restore or improve a bodily function, or
4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Benefit Booklet.
5. for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Benefit Booklet.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:
- 1) Mastectomy for Gynecomastia
- 2) Mandibular/Maxillary orthognathic surgery
- 3) Adjustable Band for Treatment of Non-synostotic plagiocephaly and brachycephaly in infants
- 4) Port Wine Stain surgery

**Skilled Nursing Facility Services** Benefits are provided for inpatient skilled nursing facility services and rehabilitative therapy. Benefits are limited to 100 days per calendar year. We do not cover custodial confinement.

**Smoking Cessation** Benefits are provided for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. To be eligible for benefits, these products and medications must be prescribed by your physician.
- NRT products can include but are not limited to, nicotine patches, gum, or nasal spray.
- We provide benefits for physician office visits for follow-up smoking cessation education and counseling.
- We provide benefits for completing an approved smoking cessation program.

Please see your Benefit Summary for applicable copayment, coinsurance, deductibles, and limitations that apply.

**Speech Therapy** Benefits are provided for short-term speech therapy on an outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed professional acting within the scope of his/her license. Please see your Benefit Summary for limits that apply.

No benefits are provided for:
- Deficiencies resulting from mental retardation; or
- Dysfunctions that are self-correcting, such as language treatment for young children with natural
dysfluency or developmental articulation errors

**Sterilizations and Reverse Sterilizations** Benefits are provided for sterilizations and services to reverse voluntarily induced sterility.

**Surgical Services** Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care. For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Customer Service.

**Telemedicine** Benefits are provided for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.

**Walk In Center** Benefits are provided for services rendered at participating Walk In Centers that pertain to a sudden, serious, or unexpected illness, injury or condition to prevent a Covered Person/Participant’s present health care condition from deteriorating. A Walk In Center is NOT an emergency room facility. Walk In Center care is NOT emergency care. Walk In Center care includes services that are needed immediately to relieve pain, reach a diagnosis, or have a specific health condition treated.

Designated Walk In Center providers typically provide care for the following types of conditions:
- Ear infections
- Sinus infections
- Colds
- Flu
- Strains
- Sprains
Section Five
Exclusions

This section, along with the “Covered Services” section, explains the types of health care services the Plan will and will not provide benefits for. The exclusions listed below are in addition to those set forth elsewhere in this Benefit Booklet. Charges you pay for services related to non-covered services do not count toward any deductible, coinsurance, or out-of-pocket limits.

**Acupuncture** Benefits are not provided for acupuncture.

**Alternative Medicines or Complementary Medicines** Benefits are not provided for alternative or complementary medicine. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by Anthem Blue Cross and Blue Shield’s Medical Director. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

**Artificial Hearts** Benefits are not provided for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

**Benefits Available from Other Sources** Benefits are not provided for any services to the extent that there is no charge to you or to the extent that you can recover expenses through a federal, state, county, or municipal law. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Medicaid.

**Biofeedback** Benefits are not provided for biofeedback.

**Blood** Benefits are not provided for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

**Commercial Weight Loss Programs** – Weight loss programs [not approved by us], whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate of Coverage.

This exclusion includes, but is not limited to, commercial weight loss programs (for example Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

**Cosmetic Services** Benefits are not provided for cosmetic services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Examples of cosmetic services include, but are not limited to: surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the
treatment of breast cancer.

**Custodial Care** Benefits are not provided for services, supplies or charges for Custodial Care, domiciliary or convalescent care, whether or not recommended or performed by a professional.

**Dental Services** Benefits are not provided for orthognathic surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in the “Covered Services” section.

**Department of Veterans Affairs** Benefits are not provided for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its hospitals, or facilities if the treatment is related to your service connected disability.

**Experimental/Investigational Services** Benefits are not provided for any drugs, supplies, providers, medical, or health care services that are experimental/investigational. This exclusion includes the cost of all services from a provider or professional including the cost of all services while you are an inpatient receiving an experimental/investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials are considered experimental/investigational.

**Facilities of the Uniformed Services** Benefits are not provided for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.

**Family Planning Services** Benefits are not provided for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

**Food or Dietary Supplements** – We do not provide Benefits for nutritional and/or dietary supplements, except as provided in this Certificate of Coverage or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

**Genetic Testing and Counseling** Benefits are not provided for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition.

**Government Institutions** Benefits are not provided for any services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government.

**Health Club Memberships** – We do not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

**Hearing Care** Benefits are not provided for hearing examinations except for screening Participants under the age of 19 years or when related to injury or disease. Please see “Hearing Care” in the Covered Services section for benefits for hearing aids.
Infertility Benefits are not provided for any treatment, services or drugs to enhance fertility. In-vitro fertilization and intravaginal conception are also not covered. Surrogate donors, male or female, are not covered.

Leased Services and Facilities Benefits are not provided for any health care services or facilities that are not regularly available in the provider you go to, that the provider must rent or make special arrangements to provide, and that are billed independently.

Maintenance Therapy Benefits are not provided for maintenance services, treatments or therapy.

Major Disaster, Epidemic, or War In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, we will make a good faith effort to provide or arrange for covered services. The Plan will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel. Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

Massage Therapy – We do not provide Benefits for massage therapy when services are not part of an active course of treatment and are not performed by a Covered Professional (Please see definition of Covered Professional.). Services by a massage therapist are not covered.

Medically Unnecessary Services Benefits are not provided for any treatment, services, or supplies that do not meet the definition of medically necessary health care.

Medicare Benefits may not be provided in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payor regulations. If you are enrolled in Medicare Part A and/or Part B, and Medicare is the primary payor, the Plan may provide benefits only for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the primary payor, the Plan may pay benefits as if Medicare had made their primary payments for Medicare Part A and/or Part B, even if you fail to exercise your right to premium free Medicare Part A coverage.

Mental Health, Substance Abuse Treatment and Lifestyle Services Benefits are not provided for any of the following services or any services relating to:
- Smoking clinics;
- Sensitivity training;
- Encounter groups;
- Educational programs except as indicated in the “Covered Services” section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for hospice care services);
- Activities whose primary purpose is recreational and socialization.

Miscellaneous Expenses Benefits are not provided for provider or professional charges to provide required information to process a claim or application for coverage. We do not provide benefits for any additional costs associated with an appeal of a claim decision.

Missed Appointments Benefits are not provided for missed appointments. Providers and/or professionals may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No benefits are available for these charges. You are solely responsible for these charges.
Orthognathic Surgery  Benefits are not provided for orthognathic surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.

Orthotic Devices  Benefits are not provided for orthotic devices unless stated as covered in the “Covered Services” section of this contract.

Personal Comfort Items  Benefits are not provided for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

Physical and Occupational Therapy  Benefits are not provided for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs  Benefits are not provided for the following:
- Any refill in excess of the number specified by the physician or for refills dispensed after one year from the date of original prescription order;
- Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides;
- Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form;
- Prescription drugs for the treatment of weight reduction/anorectics;
- Medication that is taken by or administered to an inpatient;
- Experimental or investigational drugs or any Food and Drug Administration (FDA) Treatment Investigational New Drugs (IND), unless the intended use of the drug is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug is recognized in one of the standard reference compendia or in peer-reviewed medical literature;
- Disposable supplies such as alcohol, cotton balls, or bandages used to administer medications;
- Prescription drugs dispensed by a physician;
- Prescription drugs used to enhance fertility;
- Prescription drugs approved by the federal Food and 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.

Preventive Care  Benefits are not provided for preventive care and well-care services, unless otherwise stated in the “Covered Services” section.

Prostheses  Benefits are not provided for dental prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes.

Refractive Eye Surgery  Benefits are not provided for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

Routine Foot Care  Benefits are not provided for any services rendered as part of routine foot care. Please see the "Covered Services" for foot care that is covered.

Services After Your Contract Ends  Benefits are not provided for services that are provided after your contract ends unless your group cancels coverage with Anthem BCBS and you are an inpatient on the group cancellation date. 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.

**Services Before the Effective Date** Benefits are not provided for any treatment, services, supplies, medical equipment, or prostheses rendered to you or received before your individual effective date of coverage. Services you receive during an inpatient stay that started before you enrolled are covered only as of your effective date on this contract. For an inpatient stay, care that is provided before your effective date is not covered.

**Services by Ineligible Providers or Professionals** Benefits are not provided for services provided by any provider or professional not listed as an eligible provider or professional in this contract.

**Services by Relatives or Volunteers** Benefits are not provided for any services provided in any capacity by immediate family members or step-family members, for example, spouse, domestic partner, father, mother, brother, sister, son or daughter. We do not provide benefits for services by volunteers, except as outlined in the “Hospice Care Services” provision.

**Services Not Listed As Covered** Benefits are not provided for any service, procedure, or supply not listed as a covered service in this contract.

**Services Related to Non-Covered Services** Benefits are not provided for services related to any non-covered service or to any complications and conditions resulting from any non-covered service.

**Sex Changes** Benefits are not provided for any services related to any transsexual operation.

**Speech Therapy** Benefits are not provided for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

**Surrogate Mother Services** – We do not provide Benefits for any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

**Temporomandibular Joint (TMJ) Syndrome Services** Benefits are not provided for surgical and non-surgical examination; diagnosis, including invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-covered services include but are not limited to: physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound, or diathermy; behavior modification such as biofeedback, psychotherapy; appliance therapy such as occlusal appliances (splints) or other oral prosthetic devices and their adjustments; orthodontic therapy such as braces; prosthodontic therapy such as crowns, bridgework; and occlusal adjustments.

This exclusion does not apply to services listed as covered in the “Dental Services” provision.
**Travel Expenses** Benefits are not provided for any travel expenses, whether or not the travel is recommended by a professional.

**Vision Care** Benefits are not provided for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. We do not provide benefits for the prescription, fitting, or purchase of glasses or contact lenses except when medically necessary to treat accommodative strabismus, cataracts, or aphakia.

**Workers’ Compensation** Benefits are not provided 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, the Plan does 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.

The plan 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, as discussed in the “Benefit Determinations, Payments and Appeals” section.
Section Six  
Benefit Determinations, Payments and Appeals  

Benefit Determinations  

The Contract Administrator, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the contract. The determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are medically necessary, investigational/experimental, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowance. However, you may utilize all applicable Complaint and Appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under your Plan. Your responsibility may take the form of a coinsurance percentage, a deductible, or a copayment amount. Please see your Benefit Summary for the coinsurance, deductible and copayment amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your coinsurance, deductible, or copayment amount directly to the professional or hospital or other provider of care. If you have coinsurance responsibility that is based on a percentage, you will pay your coinsurance percentage based on the hospital’s or provider’s discounted charge or negotiated amount, or the Contract Administrator’s Maximum Allowance for professionals. Note: The Contract Administrator cannot prohibit non-network providers from billing you for the difference in the non-network provider’s charge and the Maximum Allowance.

All benefits for covered services will be based on any discounted charge for hospital service or the Contract Administrator’s Maximum Allowance for professional services.

The Plan’s payment will consist of a percentage of the Maximum Allowance after any copayments and deductibles have been applied or a fixed or capitated amount.

The Contract Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, prescription drugs, mental health, and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Contract Administrator’s behalf.

Benefit Levels  
There are two levels of benefits under this Plan:

Services authorized or provided by your primary care physician These services are reimbursed at the higher level of benefits. This level is referred to as your Primary Care Physician Benefit Level on your Benefit Summary.

Self-referred services These services are reimbursed at the lower level and deductibles and coinsurance apply. Should you decide to self-refer for services, a benefit payment is made for covered services, but at a lower level. In most cases, your obligation will be greater when you do not obtain authorization or receive services from your primary care physician. This level is referred to as your Self-Referred Benefit Level on your Benefit Summary.
How Your Deductible Works
Each calendar year before benefits can be paid for self-referred covered services, you must pay your deductible.

**Family Deductible** Under family coverage, if the total family expenses for self-referred covered services exceed two times the individual deductible, then your family deductible under this Plan has been met for the calendar year. In this case, all family members will be eligible for self-referred benefits for the rest of the calendar year without meeting further deductibles. One family member may not meet the family deductible amount. The family deductible amount must be satisfied by at least two family members.

**One Deductible For a Common Accident** Under family coverage, if two or more family members are injured in the same accident, only one deductible will apply for all covered services resulting from that accident during a calendar year.

Copayments and Coinsurance
Copayments and coinsurance may apply to services performed or authorized by your primary care physician and/or self-referred services. Please see your Benefit Summary for copayment amounts and coinsurance amounts and limits. If prior approval has been granted and services are received from a provider that does not have a written participation agreement with the Contract Administrator, there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowance in addition to any applicable copayment, coinsurance or deductible. The Contract Administrator cannot prohibit non-network providers from billing you for the difference in the non-network provider’s charge and the Maximum Allowance.

**Copayments** For some services, your share of the cost is a fixed dollar amount. Copayment amounts do not count toward any coinsurance or out-of-pocket limit under this contract except for copayments for inpatient hospital services which may be included under the primary care physician benefit level as indicated on your Benefit Summary.

**Coinsurance** For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the coinsurance amount. Coinsurance amounts you pay toward non-listed mental health services do not count toward your coinsurance limit.

**How Your Coinsurance Limit Works** Under family coverage, if the total family coinsurance expenses exceed two times the individual coinsurance limit, your family coinsurance limit under this contract has been met for the calendar year. In this case, all family members will be eligible for benefits for the rest of the calendar year without paying further coinsurance subject to the separate coinsurance limit provision below.

**Separate Coinsurance Limits** There are separate coinsurance amounts and limits for your Primary Care Physician Benefit Level and for your Self-Referred Benefit Level. Coinsurance amounts paid under your Primary Care Physician Benefit Level do not count toward coinsurance limits under your Self-Referred Benefit Level. Coinsurance amounts paid under your Self-Referred Benefit Level do not count toward coinsurance limits under your Primary Care Physician Benefit Level.
Out-of-Pocket Limits
Your annual out-of-pocket expenses for your deductible, coinsurance, and inpatient hospital copayments, which may be included under the primary care physician benefit level, may be limited. Please refer to your Benefit Summary for annual out-of-pocket limits that apply to services provided by primary care physicians and for self-referred services.

Once you reach the annual out-of-pocket limit, no further deductibles, coinsurance, and inpatient hospital copayments, which may be included under the primary care physician benefit level, apply for the remainder of the calendar year. The copayment amounts, except for the inpatient hospital copayments, continue to apply after the annual out-of-pocket limits are met.

Copayments, penalties for not obtaining pre-admission review, and amounts over the Maximum Allowance do not count toward the out-of-pocket limit. There are separate out-of-pocket limits for care provided by or authorized by your primary care physician (PCP) and care covered at the self-referred benefit level. Coinsurance you pay for services under the PCP benefit level do not count toward the out-of-pocket limit for self-referred care. Deductibles and coinsurance you pay for self-referred services do not count toward your out-of-pocket limit under the PCP benefit level.

Benefit Maximums
Specific benefit maximums for each covered Participant may apply for non-listed mental health and other services. These maximums are listed on your Benefit Summary or in the contract.

Plan Changes
The Plan Administrator may change this contract at any time provided the changes are in accordance with all applicable laws.

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

Confidentiality
Any information pertaining to your diagnosis, treatment or health obtained from either your physician, provider or you will be held in confidence. The Plan Administrator or Contract Administrator may use or disclose this information only to the extent required or permitted by law. Please refer to the Plan’s privacy protection annual notice for our privacy policies and procedures.

Statements and Representations
The statements you make on your application for coverage under this Plan are representations and not warranties.

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

Claims Procedure

How to Claim Benefits In most instances, providers and professionals will file your claims with the Contract Administrator. However, you may need to submit a claim for reimbursement for self-referred services and for services from non-participating providers and professionals.

To receive claim forms, contact your group or call the Customer Service Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

Time Limit for Filing Claims The Contract Administrator must receive proof of a claim for reimbursement for a covered service no later than 365 days after that service is received. There may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Participant appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information Providers and professionals often have information needed to determine your coverage. As a condition for receiving benefits under this contract, you or your representative must provide all of the medical information needed to determine your eligibility for coverage or to process your claim.

Non-Transfer of Benefits Your benefits under this contract are personal to you. You cannot assign or transfer them to any other person.

Assignment of Payments You may assign benefits provided for covered services to the provider of the care.

Non-Compliance If the Plan Administrator does not enforce compliance with any provision of this contract, the Plan Administrator has not waived compliance and is not required to allow non-compliance of that provision or any other provision at any time, in any case.

Examination of Insured To ensure that all claims are valid, the Contract Administrator may require the Participant to have a physical or mental examination at the Plan’s expense.

Claims Payment

This explains how benefits for covered services will be paid. In most cases, you will receive maximum benefits when care is provided or authorized by your primary care physician. The Contract Administrator reserves the right to pay benefits to another person if so ordered by a court of competent jurisdiction. You have the right to appeal as outlined later in this section.

Professional and Provider Payment When a network professional renders a covered service, the payment for the service is based on a maximum allowance agreed to by him or her. In addition to the maximum allowance, an eligible network professional can receive additional payments if he or she has met certain quality standards.

Payment will be based on the most cost effective means that can safely be administered. You can contact the Contract Administrator to find out the Maximum Allowance for a service by calling the telephone number
on your ID card; the Maximum Allowance is calculated by various methodologies.

Network providers are paid in several different ways, including but not limited to discounts from regular charges and fixed fees agreed to by them.

**Primary Care Physician Services** If your claim from a network professional primary care physician is approved, benefits will be paid directly to your primary care physician. Payment will be based on the most cost effective means that can safely be administered. Except for copayments, in most cases, you are not required to pay any balances to your primary care physician for covered services. If more than a copayment applies, you are not required to pay any balances to your primary care physician until after the Contract Administrator determines the benefits that will be paid. Network professional Primary care physicians rendering a covered service agree to limit their charges to the Maximum Allowance.

**Network Providers and Professionals** If your primary care physician has authorized services from a network provider or professional, benefits will be paid directly to that provider or professional. Payment will be based on the most cost effective means that can safely be administered. Except for copayments, you are not required to pay any balances to the network provider or professional until after the Contract Administrator determines the benefits that will be paid. Network providers and professionals rendering a covered service agree to limit their charges to the Maximum Allowance.

Your network professional’s agreement for providing covered services may include financial incentives or risk sharing relationships related to provision of services or referrals to other professionals, including network professionals and non-network professionals and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your professional or Anthem.

Note: When services are rendered at a network provider by a non-network professional, you will be responsible for amounts over and above the Maximum Allowance paid to the non-network professional.

**Non-Network Providers and Professionals** Your primary care physician may refer you to a provider that does not have a written agreement with Anthem. Benefits will be provided for covered services rendered by non-network providers or professionals only if such services are not available from a network provider or professional and/or prior approval has been granted by Anthem. Anthem will base this decision on factors such as the non-network provider’s ability to meet certain standards for licensure and expertise to meet the needs of the Participant. Payment will be based on the most cost effective means that can be safely administered. If you self-refer to a provider or professional that does not have a written agreement with Anthem, the self-referred level of benefits will apply and you may be responsible for any remaining balance. Anthem will pay claims directly to you or the non-network provider or professional. Anthem will not provide benefits for services which were referred to non-network providers or professionals if the referral was not pre-approved by Anthem.

**Self-Referred Services** If your claim for self-referred services is approved, benefits will be paid directly to you, unless Anthem has a participating agreement with that provider or professional, in which case, payment will be made directly to the participating provider or professional.

**Out-of-State Providers and Professionals** If your primary care physician refers you to an out-of-state provider or professional with the Contract Administrator’s prior approval, benefits will be provided at the primary care physician benefit level. If you self-refer to an out-of-state provider or professional, benefits will be provided at the self-referred level of benefits. The Contract Administrator cannot prohibit out-of-state providers and professionals from billing you any balance remaining after they have made the payment based on the maximum allowable amount, except as otherwise provided under the BlueCard
BlueCard Program When you obtain health care services through the BlueCard program outside of Maine, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Plan”) passes on to the Contract Administrator.

The negotiated price may consist of any or all of the following:

1. A simple discount which reflects the actual price paid by the Host Plan.
2. An estimated price that factors into the actual price expected settlements, withholds, non-claims transactions, or other types of variable payments, with your health care provider or with a specified group of providers.
3. Billed charges reduced to reflect an average expected savings after taking into account the same special arrangements used to obtain an estimated price.

The price that reflects average savings may result in a greater variation (more or less) from the actual price paid than will the estimated price.

The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Also, laws in a small number of states may require Blue Cross and/or Blue Shield Plans to add a surcharge or to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim. Should any state laws require a surcharge or Participant liability calculation methods that differ from the method outlined above, Anthem would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Hospitals Outside of the United States Benefits are provided 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. Please refer to the “Utilization Management” and “Your Primary Care Physician” sections for details pertaining to authorizations and referrals.

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 the Contract Administrator receives this information, you will be reimbursed for covered services according to the terms of this Plan.

Pharmacy Benefit Management
The Pharmacy Benefits available to you under this Plan are managed by a pharmacy benefits management (PBM) company with which Anthem contracts to manage your Pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a mail service Pharmacy, and clinical services that include tier management.

The management and other services provided include, among others, making recommendations to, and updating, the tier listing and managing a network of retail pharmacies and operating a mail service
Pharmacy. The PBM, in consultation with Anthem, also provides services to promote and enforce the appropriate use of Pharmacy Benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

**Payment for Prescription Drug Claims**
To obtain Benefits for Prescription Drugs, present your identification card to any Pharmacy that has an agreement with the PBM, in this or any other state. You must pay the applicable amounts shown on your Benefit Summary. The participating Pharmacy will submit the claim for you and the PBM will directly pay the Pharmacy the balance due. Please call Customer Service at the telephone number on your ID card if you have questions about the participation status of a Pharmacy.

If you use a Pharmacy that does not have an agreement with the PBM, or if you do not use your identification card, you must pay the Pharmacy the entire cost for the prescription and submit a claim form for reimbursement. Claim forms are available by contacting a Customer Service Representative.

If you receive Prescription Drugs from a non-participating Pharmacy or if you do not use your identification card, you may receive a reduced benefit. We will reimburse you based on the amount we would have paid to a participating Pharmacy less your share of the cost.

Your financial responsibility (Copayments) will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, or similar vendors or funds received by the plan from the Pharmacy Benefits Manager.

Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the Pharmacy or the Pharmacy Benefits manager that fills your prescription.

No payment will be made by us for any Covered Service unless our negotiated rate exceeds any applicable Copayment for which you are responsible.

**Prescription Drugs By Mail**
To obtain Benefits for Prescription Drugs through the mail order Pharmacy, complete a mail order Pharmacy form, available through our Customer Service Department, and mail it with your prescription. You must enclose the applicable Copayment amount indicated on your Benefit Summary.

**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 Participants 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.

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. **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.

2. **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.

3. **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.

4. **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.

5. **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.

6. **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 provision;
- Exchange information with an insurance company or other party;
- Recover our 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.

**Disability**

If your group coverage terminates with us while you are totally disabled, benefits for covered services directly relating to the condition causing total disability remain available to you until you are no longer disabled, you reach any contract maximums, 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. If you have
replacement coverage, the replacement coverage will pay as primary coverage during this time, and we will 
pay as secondary coverage for the covered expenses directly relating to the condition causing total 
disability.

Under the contract, disabled means:
- If you were employed, you are unable to work in your regular and customary occupation because of 
ilness or injury;
- If you were not gainfully employed, you are unable to engage in most normal activities of a person of 
like age in good health.

Our coverage of losses during your total disability has the same limits that apply to employees or members 
who are not disabled.

**Special Information If You Become Eligible For Medicare**

You must notify the Contract Administrator if you become eligible for premium free Medicare Part A. 
Failure to notify the Contract Administrator could result in retroactive benefit adjustments if Medicare 
would have been or is the primary payor. You may choose to continue your coverage once you are eligible 
for premium free Medicare Part A and Medicare Part B coverage. However, your contract will not provide 
benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to 
exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you become 
eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans 
are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare 
Supplement plans have limited enrollment periods, it is important to evaluate these plans as soon as you are 
eligible for Medicare.

**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 the Plan provides health care benefits for 
treatment of your injury or illness, the Plan has the right to recover, from any such payment (whether by 
judgment, suit, compromise, settlement or otherwise) up to the total benefit paid, on a just and equitable 
basis. The process of recovering these expenses is called subrogation.

The Plan also has 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, the Plan is entitled to the 
reasonable cash value of the services.

By accepting coverage you agree:
- Your signed application for coverage is your authorization of the right of subrogation;
- To notify the Contract Administrator of any event which could result in legal action, a claim against a 
third party, or a claim against your own insurance;
- To notify the Contract Administrator of any payments you receive as a result of legal action, a claim 
against a third party, or a claim against your own insurance;
- To cooperate with the Contract Administrator in exercising its right of subrogation by providing all 
information requested;
- To sign documents the Contract Administrator deems necessary to protect its rights; and
- To do nothing to interfere with these subrogation rights.

If you do not comply with the above, you may be responsible for expenses the Contract Administrator
Complaints and Appeals

Complaints
Customer Service Representatives are available to assist Participants in the resolution of complaints concerning claims administration, benefit determination, eligibility, or medical care provided to you by your provider or professional. A Customer Service Representative may need to forward your complaint to the appropriate internal department for response. The internal staff receiving the Participant complaint will conduct an investigation and promptly issue a decision to the Participant on the complaint, either in writing or by telephone. You will receive a response within twenty (20) working days of Anthem BCBS’s receipt of your complaint. If additional information is needed, a final decision will be issued within twenty (20) working days of the Contract Administrator’s receipt of the additional information. If your complaint is not satisfactorily resolved, you may seek help through the appeal process outlined below.

Complaints Requiring Immediate Intervention
If you are dissatisfied with a decision regarding an urgent care situation, the Contract Administrator will immediately work with the health care professional or provider involved to respond quickly to the concern. This will occur before the need for services, whenever possible. If services are already in progress, the Contract Administrator will promptly notify the Participant of the decision, so that he or she may decide, if an adverse determination is given, whether to receive services for which he or she may be financially responsible and which may not be covered by the Plan.

Appeals

Level One Appeal Process
You or your authorized representative, if dissatisfied with the Contract Administrator’s initial decision or the decision on a registered complaint, may appeal the decision to the Appeals Department at the Contract Administrator. An appeal may be submitted orally or in writing and must include specific reasons why you or your authorized representative do not agree with the issued decision. Appeal of a decision must be filed within one-hundred-eighty (180) calendar days of the date the decision was issued, unless there are extenuating circumstances.

The Contract Administrator reserves the right to investigate the reason for the delay and determine whether the circumstances warrant acceptance of the Level One Appeal beyond the 180-day time frame.

On appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate clinical peer or peers who have not been involved with a prior decision. Additional information may be submitted by or on behalf of the Participant, any treating professional, or Anthem BCBS. A decision will be issued within twenty (20) working days of receipt of the request for an appeal.

Once a decision is issued, the Participant, or Participant representative, if dissatisfied with the outcome, may submit a voluntary second level appeal to Anthem BCBS, request an external review, or bring legal action against the Contract Administrator.

If you choose to pursue a voluntary second level appeal, you will have the opportunity to appear before the review panel to present your concerns regarding our adverse benefit determination.

Level Two Appeal Process (Voluntary)
You or your authorized representative, if dissatisfied with the outcome of the Level One Appeal, may appeal the decision to the Appeals Department at the Contract Administrator. An appeal must be in writing and
include specific reasons you or your authorized representative do not agree with the issued decision. It must be filed within one-hundred-eighty (180) calendar days of the date the Level One Appeal decision was issued, unless there are extenuating circumstances. The Contract Administrator reserves the right to investigate the reason for the delay and determine whether the circumstances warrant acceptance of the Level Two Appeal beyond the 180-day time frame.

On a Level Two Appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate clinical peer or peers who have not been involved with the prior decision. Additional information may be submitted by or on behalf of the Participant, any treating professional, or the Contract Administrator. **You or your authorized representative, may appear before the review panel.** If you do not request the opportunity to appear in person, the decision for second level grievance reviews will be issued within 30 calendar days. If you do request the opportunity to appear in person, the review will be conducted within forty-five (45) working days of receipt of the participant’s level two appeal. A written decision will be issued to the Participant within five (5) working days of completing the review. Once a final decision has been issued by the Second Level Appeal panel, the Participant may request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS.

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

**External Review Process**
You or your authorized representative, if dissatisfied with the outcome of the Level One or Voluntary Level Two Appeal relating to an adverse health care treatment decision rendered by Anthem BCBS, may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, pre-existing condition determinations and determinations 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 authorized representative may not make a request for external review until you have exhausted Level One of the internal appeals process unless:

- Anthem BCBS has failed to make a decision on an appeal within the time period required;
- Anthem BCBS and you mutually agree to bypass the internal appeals process;
- The life or health of the member is in serious jeopardy; or
- The member has died.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written decision must be made by the independent review organization within thirty (30) days of receipt of a completed request for external review from the Bureau of Insurance. An external review decision must be made as expeditiously as a member’s medical condition requires but no more than 72 hours after receipt of the completed request for external review if the 30-day time frame described above would seriously jeopardize the life or health of the member or would jeopardize the member’s ability to regain maximum function.

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

**Legal Action Against the Plan**
No legal action may be brought against the Plan until the Participant or the Participant’s authorized
representative has exhausted the complaint and appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the underlying adverse Level One Appeal decision; or
- The date of the Level One grievance determination.
Section Seven
Definitions

This section explains the meaning of some of the words in this Benefit Booklet. Other words may be defined in the text.

Accident Care Treatment of an accidental bodily injury sustained by the Participant that is the direct cause of the condition for which benefits are provided and that occurs while the plan is in force.

Affidavit of Domestic Partnership The University Affidavit of Domestic Partnership signed by the subscriber and domestic partner and duly notarized, which attests to shared financial obligations, shared primary residence, and mutual responsibility for the welfare of the subscriber and domestic partner.

Ambulatory Surgical Facility A facility that meets both of the following requirements:
• Licensed as an ambulatory surgery center, or is Medicare certified; and
• Meets the Contract Administrator’s standards for participation.

Amendment An addition, change, correction, or revision to the terms and conditions of this Benefit Booklet.

Annual Enrollment A period of time during the year in which an eligible employee who had previously waived enrollment in the Plan may enroll or add dependents. Enrolled Participants may also terminate enrollment. Participants may also make changes to benefit elections during annual enrollment.

Annual Out-of-Pocket Limit The limits on the deductible and coinsurance you pay each year. Separate out-of-pocket limits apply to the Primary Care Physician Benefit Level and the Self-Referral Benefit Level. After you meet an annual out-of-pocket limit, you pay no further deductible or coinsurance for most services under that benefit level.

Annual Review Date The date set by the Contract Administrator and the University on which the contract renews each year.

Appeal A request for a review of the initial decision, a decision on a registered complaint, or determination of medical necessity.

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.

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 Booklet The document that specifies the health care benefits available to Participants under this Plan.

Benefits Payments made on your behalf under this Plan.
Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding calendar year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Capitation A method of payment to professionals or providers for specific, agreed upon medical services based on a fixed dollar amount for each Participant on a monthly basis. The amount paid is based on the Participant’s gender and age rather than an amount per service or visit.

Chiropractor A person who is licensed to perform chiropractic services, including manipulation of the spine.

Coinsurance The percentage the Plan pays toward the cost of some covered services and the percentage you pay.

Community Mental Health Center An institution that meets both of the following requirements:
- Licensed as a comprehensive level community mental health center; and
- Meets the Contract Administrator’s standards for participation.

Contract This Benefit Booklet, any amendments, riders, or attached papers; the Administrative Services Agreement; your application; and the Benefit Summary.

Contract Administrator Anthem Blue Cross and Blue Shield.

Contract Holder The employer, association, or trust that applies for and accepts this coverage on behalf of its Participants. The University is the Contract Holder.

Copayment A fixed dollar amount or percentage required to be paid by each Participant for certain covered services under this contract. Please refer to your Benefit Summary for specific information.

Cosmetic Services Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Service Services, supplies or treatment as described in this Benefit Booklet. To be a covered service the service, supply or treatment must be:
- Medically necessary or otherwise specifically included as a benefit under this Benefit Booklet.
- Within the scope of the license of the professional performing the service.
- Rendered while coverage under this Benefit Booklet is in force.
- Not experimental or investigational or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by us if such preauthorization is required in this Benefit Booklet.

Creditable Coverage (Prior Coverage) Coverage under an individual or group contract or policy that was in effect within 3 months before you were eligible for coverage under this contract if you apply when initially eligible, or within 3 months of your effective date if you apply as a late enrollee. Creditable coverage includes group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, public health plan, the Peace Corps health benefit plan, S-CHIP, or a qualified foreign health plan. In calculating the period of creditable coverage, all periods of coverage under all types of creditable coverage are added together unless there is a consecutive 90-day or longer break in the time period the individual has creditable
Custodial Care  Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Administering normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

Day Treatment Patient A patient receiving mental health or substance abuse care on an individual or group basis for more than two hours but less than 24 hours per day in either a hospital, rural mental health center, substance abuse treatment facility, or community health center. This type of care is also called partial hospitalization.

Deductible The amount you may be required to pay each year toward the Maximum Allowance for certain covered services before this Plan provides benefits.

Dental Service Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the lamina dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible employee’s lawful spouse, domestic partner, unmarried children and others as outlined in the “Eligibility, Termination and Continuation of Coverage” section of this Benefit Booklet. Children of the domestic partner are eligible for coverage only when the employee may claim the child(ren) as a federal income tax exemption.

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

Discount Favorable rates or discounts the Contract Administrator has negotiated with hospitals and other providers. Participants benefit from these rates or discounts since they are applied prior to calculating your share of costs. Discounted charges reduce the expenses paid by the Plan which helps to lower the contract costs.
Domestic Partnership A relationship between two people who are:
- At least 18 years old and mentally competent to contract,
- Not legally married to another person,
- Each other's sole domestic partner,
- Jointly responsible for each other's welfare and who share financial obligations,
- Living together for at least six (6) continuous months in a close, committed and exclusive personal relationship that is meant to be lasting,
- Not related by blood to a degree that would prohibit marriage in the state of Maine.

To apply for coverage, domestic partners must complete and sign a University Affidavit of Domestic Partnership. The employee and domestic partner may be required to provide satisfactory proof that the partnership meets the Plan definition.

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

Durable Medical Equipment Equipment that meets all of the following criteria:
- Can withstand repeated use;
- Is used only to serve a medical purpose;
- Is appropriate for use in the patient’s home;
- Is not useful in the absence of illness, injury, or disease; and
- Is prescribed by a physician.

Durable medical equipment does not include fixtures installed in your home or installed on your real estate.

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 first day of coverage under this Plan.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:
- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:
- That there is inadequate time to safely transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:
- Placing the Participant’s physical and/or mental health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require emergency services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs.

**Enrollment Date** The first day of coverage or, if there is a waiting period, the first day of the waiting period.

**Enrollment Period** The period following your initial eligibility for enrollment.

**Experimental or 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 BCBS determines to be experimental or investigational.

Anthem BCBS 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 BCBS. In determining whether a service is experimental or investigational, Anthem BCBS will consider the information described in subsection (c) and assess the following:

(i) Whether the scientific evidence is conclusive 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 BCBS 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 BCBS 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.

**Family Medical Leave** Leave granted a Participant under the Family Medical Act of 1993. See the "Family and Medical Leave" section for additional information.

**Family Planning Agency** An agency that meets both of the following requirements:
- Is a delegated family planning agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets the Contract Administrator’s standards for participation.
Formulary The list of pharmaceutical products, developed in consultation with physicians and pharmacists, approved for their quality and cost effectiveness.

Freestanding Imaging Center An institution that meets both of the following requirements:
• Licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center; and
• Meets the Contract Administrator’s standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:
• Has a medical staff of physicians, nurses and licensed anesthesiologists;
• Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
• Has equipment for emergency care;
• Has a blood supply;
• Maintains medical records;
• Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis;
• Is licensed in accordance with the law of the appropriate legally authorized agency; and
• Meets the Contract Administrator’s standards for participation.

Grace Period The 31 days that begin with and follow the due date of an unpaid subscription charge.

Group The employer that provides coverage for its employees. Your group is the University of Maine System, who is also the Contract Holder/Plan Sponsor.

Home Health Agency An institution that meets both of the following requirements:
• Licensed as a home health agency; and
• Meets the Contract Administrator’s standards for participation.

Hospice A facility that meets both of the following requirements:
• Licensed as a hospice; and
• Meets the Contract Administrator’s standards for participation.

Hospice Care Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

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

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

Independent Laboratory An institution that meets both of the following requirements:
• Licensed as an independent medical laboratory; and
• Meets the Contract Administrator’s standards for participation.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate
independent professional associations.

**Inpatient** A registered bed patient who occupies a bed in a hospital, skilled nursing facility, or residential treatment facility. A patient who is kept overnight in a hospital solely for observation is not considered a registered inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an outpatient.

**Inpatient Stay** One period of continuous, inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay.

**Late Enrollee** A subscriber or a dependent family member who requests enrollment under the contract holder’s group health plan following the initial enrollment period provided under the terms of the plan; or a subscriber or dependent family member who enrolls after 31 days following any of the qualifying life events described in the “Eligibility, Termination, and Continuation of Coverage” section of this contract. A late enrollee may only submit an application during the annual late enrollee enrollment period.

**Maintenance Therapy** Any treatment, service, or therapy that preserves the Participant’s level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

**Maximum Allowance** The highest dollar amount that will be paid by the Participant and the plan for a covered service based on agreements with network providers and professionals. Payment will be based on the most cost effective means that can be safely administered.

For Covered Services provided by non-network providers and professionals, the Participant’s portion of the payment will include charges over and above what would have been paid to a network provider or professional.

**Medicaid** Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

**Medically Necessary Health Care** Health care services or products provided to a Participant 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 Participant or physician or other health care practitioner.

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

**Mental Health Service** A service to treat any disorder that affects the mind or behavior regardless of origin.

**Morbid Obesity** A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published
Network Providers and Professionals  Health care providers and professionals that have a written agreement with Anthem BCBS to furnish health care services under this contract. Also referred to as participating providers and professionals.

Network Specialty Pharmacy  Any appropriately licensed pharmacy located within the United States which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render specialty drug services and certain administrative functions.

Non-Network Providers and Professionals  Health care providers and professionals that do not have a written agreement with Anthem BCBS to furnish health care services under this contract. Also referred to as non-participating providers and professionals. Providers and professionals who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this plan are also considered non-network providers.

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

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

Outpatient  A patient who receives services at a provider and who is not a registered inpatient or a day treatment patient. A patient who is kept overnight in a hospital solely for observation is considered an outpatient. This is true even though the patient uses a bed.

Participant  An eligible employee, early retiree, surviving spouse and any eligible dependents who are properly enrolled under the Plan.

Pharmacy  Any retail establishment operating under a license and in which a registered pharmacist dispenses prescription drugs. Also, the mail order facility available under the Plan.

Pharmacy and Therapeutics Committee  A committee made up of physicians and other experts in medicine and pharmacy.

Physician  See definition of “Professional.”

Plan  Your health coverage with Anthem Blue Cross and Blue Shield as the Contract Administrator and the University as the Contract Holder/Plan Sponsor.

Plan Sponsor  The University of Maine System is the Plan Sponsor.

Prescription Drugs  A narcotic or medicine approved by the federal Food and Drug Administration (FDA) for use outside of a hospital dispensed under a physician’s written order. Prescription drugs are: required by state law to be dispensed only with a prescription; required by law to display the notice, “Caution: Federal law prohibits dispensing without a prescription”; or any other drug we may approve through our drug approval process.

Primary Care Physician (PCP)  A physician, qualified Certified Nurse Practitioner, or other qualified professional, as required by law, within the network whom the Participant has designated as his or her primary care physician, and who is normally engaged in one of the following categories of practice: family
practice, internal medicine, pediatrics, or obstetrics/gynecology.

**Primary Care Physician (PCP) Benefit Level** The higher level of benefits available under this contract.

**Professional** An independently billing, licensed health care specialist acting within the scope of his or her license. Only the following professionals are eligible for payment under this contract:

- **Physicians**
  - Doctor of Medicine
  - Doctor of Osteopathy

- **Other Professionals**
  - Doctor of Optometry
  - Doctor of Chiropractic
  - Doctor of Podiatry
  - Doctor of Dentistry
  - Doctor of Psychology
  - Licensed Audiologist
  - Licensed Psychiatric Nurse Specialist
  - Licensed Clinical Social Worker
  - Licensed Marriage and Family Therapist
  - Licensed Pastoral Counselor
  - Physical Therapist
  - Occupational Therapist
  - Speech Therapist
  - Registered Nurse
  - Licensed Practical Nurse
  - Licensed Clinical Professional Counselors
  - Certified Nurse Midwife
  - Ambulance Services
  - Other professionals that have written participating agreements with us
  - Other professionals as required by law

**Prostheses** Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

**Provider** A licensed health care institution, facility, or agency. Only the following providers are eligible for payment under this contract:

- Acute-care Hospitals
- Skilled Nursing Facilities
- Rural Health Centers
- Home Health Agencies
- Ambulatory Surgery Centers
- Hospices
- Community Mental Health Centers
- Substance Abuse Treatment Centers
- Licensed Pharmacies
- Acute Care Psychiatric and Rehabilitation Hospitals
- Independent Laboratories
- Freestanding Imaging Centers
- Family Planning Agencies
- Durable Medical Equipment Providers
• Infusion Providers
• Other Providers that have written contracts with us
• Other providers, as required by law

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

**Reconstructive Procedures** Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

**Referral** Authorization given by your PCP for you to see any other professional. A referral is required for most non-emergency care; however, a referral does not guarantee or imply coverage for those services or procedures.

**Referral Service** Any covered service that cannot be performed by your PCP and for which your PCP has given you a referral to any other professional. However, a referral does not guarantee or imply coverage for those services or procedures.

**Rural Health Center** An institution that meets both of the following requirements:
- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets the Contract Administrator’s standards for participation.

**Self-Referral (or Self-Refferred)** Your choice to receive covered services not authorized or provided by your primary care physician.

**Self-Refereed Benefit Level** The lower level of benefits available under this contract.

**Service Area** For primary care, the geographic area represented by 30 minutes travel time by automobile from your place of residence or employment. For specialty care and hospital services, the geographic area represented by 60 minutes travel time by automobile from your place of residence or employment.

**Sitter/Companion** A person who provides short-term supervision of hospice patients during the temporary absence of family members.

**Skilled Nursing Facility (SNF)** An institution that meets all of the following requirements:
- Licensed as a skilled nursing facility;
- Accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients;
- Engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets the Contract Administrator’s standards for participation.

**Specialist Service** A service by a professional practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

**Specialty Drug** Prescription legend drugs which:
• Are approved to treat limited patient populations, indications or conditions;
• Are normally injected, infused or require close monitoring by a physician or clinically trained
  individual; or
• Have limited availability, special dispensing and delivery requirements, and/or require additional
  patient support – any or all of which make the drug difficult to obtain through traditional
  pharmacies.

Subcontractor  An organization or entity that provides particular services in specialized areas of
expertise.  Examples of subcontractor specialized areas of expertise include, but are not limited to,
prescription drugs, mental health and substance abuse services.  Such subcontracted organizations or entities
may make benefit determinations and/or perform administrative, claims paying, or customer service duties
on our behalf.

Subscriber  The person who enrolled for coverage under this Plan, also referred to as the Participant.

Substance Abuse  The misuse, excessive use, or improper use of alcohol or drugs to the extent that such
use contributes to physical, mental, or social dysfunction, regardless of origin.

Substance Abuse Treatment Facility  A residential or nonresidential institution that meets all of the
following requirements:
• Licensed or certified as a substance abuse treatment facility;
• Provides care to one or more patients for alcoholism and/or drug dependency;
• Is a freestanding unit or a designated unit of another licensed health care facility; and
• Meets the Contract Administrator’s standards for participation.

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

Surgical Service  A service performed by a professional acting within the scope of his or her license that is:
• A generally accepted operative and cutting procedure;
• An endoscopic examination or other invasive procedure using specialized instruments; or
• The correction of fractures and dislocations.

Telemedicine  The use of interactive audio, video, or other electronic media for the purpose of diagnosis,
consultation, or treatment.  Telemedicine does not include the use of audio-only telephone, facsimile
machine, or e-mail.

Terminal Illness  A terminal illness exists if a person becomes ill with a prognosis of 12 months or less
to live, as diagnosed by a physician.

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.

Utilization Management The process the Contract Administrator uses to determine the medical
necessity, appropriateness, efficacy or efficiency of health care services. Techniques include inpatient
admission review, continued inpatient stay review, discharge planning, post admission review and case
management.

Waiting Period The period required by your employer before enrollment in this health plan is allowed.

Walk In Center The term Walk In Center means a designated, participating free-standing center
providing episodic health services without appointments for: diagnosis; care; and treatment. Services
rendered at designated Walk In Centers that pertain to a sudden, serious, or unexpected illness, injur or
condition to prevent a Participant’s presenting health care condition from deteriorating. Walk In services are
not an emergency, but are needed immediately to relieve pain, reach a diagnosis, or have a specific health
condition treated.

You or Your The employee, retirees under age 65, and all dependents accepted for coverage under this
Plan.
Section Eight
Family and Medical Leave

Continuation of Health Coverage During Family and Medical Leave
The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of unpaid, job-protected leave during any 12 month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See your employer to find out details about how this continuation applies to you.

Reasons for Taking Leave
FMLA leave will be granted for any of the following reasons:
- Care of your child after birth;
- Placement of a child with you for adoption or foster care;
- Care of your spouse, child or parent who has a serious health condition; or
- A serious health condition that makes you unable to work.

Employee Eligibility
To be eligible for FMLA benefits, an employee must:
- Work for a covered employer;
- Have worked for the employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and,
- Work at a location where at least 50 employees are employed by the employer within 75 miles.

Advance Notice and Medical Certification
The employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

The employee ordinarily must provide 30 days advance notice when the leave is foreseeable. If the need for the leave is unforeseen, notice must be given as soon as practicable. An employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the employer's expense) and a fitness for duty report to return to work.

Continuation of Health Coverage, Job Benefits, and Protection
For the duration of FMLA leave, the employer must maintain your health coverage. You may continue the health plan for you and your dependents on the same terms as if you had continued to work. You must pay the same contributions toward the cost of the coverage that you made while working.

If you fail to make the payments on a timely basis, the employer can end the coverage during the leave if your payment is more than 30 days late. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.
**Intermittent Leave**
Under some circumstances, you may take FMLA leave intermittently which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Where FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval. FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because you are seriously ill and unable to work.

**Substitution of Paid Leave**
Subject to certain conditions, employees or employers may choose to use accrued paid leave (such as sick or vacation leave) to cover some or all of the FMLA leave. The employer is responsible for designating if paid leave used by you counts as FMLA leave, based on information provided you. In no case can your paid leave be credited as FMLA leave after the leave has been completed.

**Spouses or Domestic Partners Who Work for the Same Employer**
Spouses or domestic partners employed by the same employer are jointly entitled to combined total of 12 work weeks of family leave for the birth or placement of a child for adoption or foster care, and to care for a child or parent (but not a parent "in law") who has a serious health condition.

**Reenrollment after a FMLA Leave**
If any or all of your coverages stop while you are on a FMLA leave, when you return from leave, you are entitled to be reinstated on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

See your employer for details about continuing group coverage other than the health coverage.
Section Nine
The University's Non-Discrimination Notice

In complying with the letter and spirit of applicable laws and in pursuing its own goals of diversity, the University of Maine System shall not discriminate on the grounds of race, color, religion, sex, sexual orientation, national origin or citizenship status, age, disability, or veteran status in employment, education, and all other areas of the University. Upon request, the University provides reasonable accommodations to qualified individuals with disabilities.

Questions and complaints about discrimination in any area of the University should be directed to Sally Dobres, Equal Opportunity Director, University of Maine System, Office of Human Resources, 107 Maine Avenue, Bangor, Maine 04401, (207) 621-3199 (voice) or (207) 973-3300 (TTY/TDD).

Inquiries or complaints about discrimination in employment or education may also be referred to the Maine Human Rights Commission. Inquiries or complaints about discrimination in employment may be referred to the U.S. Equal Opportunity Commission.

If you have inquiries about the University's compliance with the following:
• Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin;
• Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of disability;
• Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex; and
• The Age Discrimination Act of 1975, which prohibits discrimination on the basis of age.

Direct them to:
The U.S. Department of Education
Office for Civil Rights (OCR)
Boston, Massachusetts 02109-4557
Telephone: (617) 223-9662 (voice) or (617) 223-9695 (TTY/TDD)

Generally, an individual may also file a complaint with OCR within 180 days of the alleged discrimination.
Section Ten
Disclosure of Protected Health Information

Disclosure of Protected Health Information from the Group Health Plan to the Sponsor under the Health Insurance Portability and Accountability Act (HIPAA)

The Health Plan is permitted to disclose Protected Health Information (PHI) to the University of Maine System as the plan sponsor to cover the plan administration functions that the plan sponsor performs, including, but not limited to, the EARLY RETIREE REINSURANCE PROGRAM (ERRP), compliance and reporting required by law, and other plan administration functions the University performs.

The group health plan will disclose PHI to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan documents have been amended to incorporate the following provisions and that the plan sponsor agrees to:

A. Not use or further disclose the PHI other than as permitted or required by the plan documents or as required by law;

B. Ensure that any agents, including contractors, to whom it provides PHI received from the group health plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI;

C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

D. Report to the group health plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;

E. Make available PHI for access by the participant in accordance with HIPAA;

F. Make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;

G. Make available the PHI required to provide an accounting of disclosures in accordance with HIPAA;

H. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of U.S. DHHS for purposes of determining compliance by the group health plan with HIPAA;

I. If feasible, return or destroy all PHI received from the group health plan that the sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

J. Ensure that the adequate separation of employees is established, as follows:

i. Employees in University Human Resources offices who have job responsibilities regarding plan administration functions will be given access to the PHI to be disclosed by the Group Health Plan, including PHI relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business;

ii. Access to and use by such employees and other persons described in paragraph (J)(i) of this section shall be restricted to the plan administration functions that the plan sponsor performs for the group health plan; and

iii. Any issues of noncompliance by persons described in paragraph (J)(i) of this section with
these plan document provisions shall be resolved in accordance with existing university disciplinary procedures and any applicable Collective Bargaining Agreement.

The plan sponsor will reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the group health plan. The plan sponsor shall—

A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan;

B. Ensure that the required adequate separation of employees is supported by reasonable and appropriate security measures;

C. Ensure that any agent, including a subcontractor, to whom it provides the PHI agrees to implement reasonable and appropriate security measures to protect the PHI; and

D. Report to the group health plan any security incident of which it becomes aware.

The plan sponsor shall provide the Group Health Plan with the written certification required above.

The Group Health Plan may disclose PHI to the plan sponsor to carry out plan administration functions that the plan sponsor performs only consistent with the above provisions.

The Group Health Plan may not disclose PHI to the plan sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
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