

CompCare

The University of Maine System Comprehensive Group Health Plan

Summary Plan Description / Certificate of Coverage



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Introduction

This Certificate contains information that you need to know about your University of Maine System (University) COMP-CARE Comprehensive coverage insured and administered by Anthem Blue Cross and Blue Shield (Anthem BCBS). You are urged to read this Certificate of Coverage carefully.

This Certificate of Coverage explains how your COMP-CARE plan works. It explains the terms, benefits, conditions, exclusions, and limitations of your coverage. It also includes information about eligibility requirements, enrollment for benefits, claim procedures and termination provisions.

The benefits described in this Certificate of Coverage are interpreted and administered according to the provisions and limitations herein. If there are coverage questions, Anthem BCBS will base all decisions on the provisions in this Certificate of Coverage.

The Certificate of Coverage, any amendments or attached papers, the Summary of Benefits, the group application, the Group Agreement, and your individual application make up your group contract and your complete coverage with Anthem BCBS for health care benefits. This Certificate of Coverage replaces any previous Certificates of Coverage you may have received.



Nancy L. Purcell
Corporate Secretary
Anthem Blue Cross and Blue Shield

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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

Presque Isle

55 North Street, Suite A

Presque Isle, ME 04769

Telephone: 207-764-8124

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 we 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 us 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 (Premiums Due)

Payment for subscription charges is due the first day of each month of coverage. To keep this coverage in effect, the University must pay the subscription charges when due. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period.

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 Member?

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; or
- 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 unmarried children (biological, adopted or stepchildren) who are:
 - Under age 19 whom you are eligible to claim as a federal income tax exemption;
 - 19 years old but less than 23 years old and 50% or more dependent on you for financial support; or
 - Under age 23, living with the subscriber's former spouse and who was enrolled as a dependent in the Plan before the divorce.

The children of a previously approved domestic partner, provided they satisfy the eligibility requirements

- A visiting foreign student who is under age 23, 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, and 50% or more dependent on the subscriber for financial support.
- A subscriber's grandchild under age 23, living with the subscriber in a parent-child relationship and 50% or more dependent on the subscriber for financial support. The subscriber cannot enroll a child and grandchild at the same time under the same certificate/policy number. The eligible child or grandchild can be covered under a separate University COMP-CARE comprehensive certificate/policy number.
- A child for whom the subscriber has received a qualified court order to provide coverage; or
- A child 19 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 23rd birthday and the child must have been covered under the Plan continuously since his or her 23rd birthday. You must submit proof of the child's condition within 31 days of his or her 23rd 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.

When a covered child reaches age 19, we will send you an application to continue the child's coverage. You must return the completed application to us if you want the child's coverage to continue.

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 COMP-CARE comprehensive group health plan, you must make contributions towards the cost of coverage.

Compliance with Public Law 2003, Chapter 451, Part Z as amended by Public Law 2003, Chapter 507, Part A.

During 2003, the Maine Legislature enacted certain provisions intended to reduce the cost of health care provided to you under the University of Maine System (UMS) Health Plan. The law requires UMS and its insurance carrier to negotiate with hospitals participating in that carrier's network to reduce the expense incurred by UMS in State fiscal year 2003-2004 by the amount of \$2,250,000 and in State fiscal year 2004-2005 by the amount of \$2,250,000.

These provisions are not intended to affect the UMS Health Plan's underlying premium rates or cost structures. The law requires that there be no changes in the current dollar level of your individual (employee or retiree) cost sharing under the UMS Health Plan. Therefore, the amounts that you currently pay under the UMS Health Plan for coinsurance amounts, deductibles, lifetime maximums, benefit differentials, or other benefit calculations will **not** change due to these provisions. The UMS Health Plan indicates that this is in accordance with applicable collective bargaining agreements and University policy for non-represented employees.

Because UMS and the insurance carrier are negotiating reductions in the standard hospital reimbursement rates, the total costs of the UMS Health Plan may decrease. Therefore, the aggregate share (or proportion) of employee/retiree cost sharing may increase as a proportion of the total cost of the Health Plan.

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.

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; or
 - c. loss of coverage under the Cub Care program.

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 COMP-CARE comprehensive plan. If you elect this Plan, this Plan will provide benefits before Medicare provides benefits.

If you elect to be covered under the COMP-CARE comprehensive 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 we 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 we have accepted payment, payment may not be refunded, and coverage may continue until the end of that period. We reserve 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 insurance carriers. 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, we may cancel the contract. If the group contract is canceled for non-payment, we will notify the subscriber of the cancellation prior to the termination date of the contract. We 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 us. We may cancel the contract by not renewing the group contract as described in the group contract.

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 Member'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 member from coverage if the member 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 member's death. The subscriber must notify the University of these events and complete a form to remove a member. 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 marry. Coverage will end on the first day of the month that occurs immediately on or after your date of marriage.
- ♦ You reach age 19 and we have not received and accepted an application for continued coverage under the subscriber's coverage. Coverage will end on the first day of the month that occurs immediately on or after your 19th birthday.
- ♦ We have accepted your application for coverage after age 19 and you then reach age 23. Coverage will end on the first day of the month that occurs immediately on or after your 23rd birthday unless you are an eligible disabled dependent, as defined in the subsection "Who is an Eligible Group Member?". We reserve the right to request verification of continued eligibility between the ages of 19 and 23.
- ♦ 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 COMP-CARE comprehensive group health plan will end when the alternate plan coverage begins.

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 in applying for coverage or filing for benefits, your contract will be canceled. In such cases the contract will be null and void. 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, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from us.

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
107 Maine Avenue
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.

Field Code Changed

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.

Section Two

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 physician.

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 our employees or the providers we contract 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 contract. In addition, we require members of our 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 contract.

Anthem BCBS Medical Policy

The purpose of medical policy is to assist in the interpretation of medical necessity. However, the Certificate of Coverage and the Group Agreement take precedence over medical policy. Medical technology is constantly changing and we reserve 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 physician or Anthem BCBS to be sure that prior authorization has been obtained.

Members' Rights and Responsibilities

You have the right to:

- ♦ Request in writing a copy of our 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 our determination of medical necessity, you have the right to appeal as outlined in the "Benefit Determinations, Payments and Appeals" section of this Certificate.

Inpatient Admission Review

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

You, your physician or the provider must call the telephone number on your ID card for review before you are admitted. It is your responsibility to make sure the call has been placed. If you do not receive pre-admission review before you are admitted for non-emergency services, benefits will be reduced by up to \$500 for the admission. 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.

If you are admitted to a non-participating hospital or other non-participating health care facility, benefits are provided 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 not be provided 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 Certificate.

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 member.

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.

Continuity of Care

If you are undergoing a course of treatment and the treating provider or professional withdraws from this network, we 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.

Inpatient Mental Health/Substance Abuse Review

Authorization for inpatient mental health and substance abuse services must be obtained through the behavioral health care manager. You, your doctor, or the provider must call for authorization. Unless you have an emergency medical condition, you must call the telephone number on your ID card for prior authorization of all inpatient mental health and substance abuse services before you receive the services. It is your responsibility to make sure you receive prior authorization for all non-emergency inpatient mental health and substance abuse services. If you do not call for authorization for inpatient mental health and substance abuse services before you receive the services, your benefits may be reduced by up to \$500. Benefits may be denied if it is determined that services received were not medically necessary.

Individual Care Management

Anthem BCBS has a care management program that is tailored to the individual. Our care managers work collaboratively with members and their families and providers to coordinate the member's health care benefits.

In certain extraordinary circumstances involving intensive care management, we may provide benefits for alternate care that is not listed as a covered service. We may also extend covered services beyond the contractual benefit limits of this plan. We will make our decision case-by-case. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. We reserve the right, at any time, to alter or cease providing extended benefits or approving alternate care. In such case, we will notify you or your representative in writing.

Section Three

Covered Services

This section, along with the “Exclusions” section, explains health care services for which we will and will not provide benefits. All benefits and covered services are subject to the deductibles, coinsurance, copayments, maximums, exclusions, limitations, terms, provisions and conditions of this contract, including any attachments and amendments or riders. Our payment for covered services will be limited by any applicable copayment, deductible, or annual or lifetime maximum. Please check your Summary of Benefits 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 we do not provide benefits for covered services that do not meet our 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 our definition of medical necessity, we will not provide benefits for it. Anthem BCBS 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 contract apply separately to each covered family member.

A member’s right to benefits for covered services provided under this Certificate 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.

Acupuncture Benefits are provided for acupuncture treatments from a qualified or licensed acupuncturist when prescribed by a physician and medically necessary.

Allergy Testing and Injections We provide benefits for allergy testing and injections.

Ambulance Service We provide benefits 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.

Ambulatory Surgery Centers We provide benefits for certain covered services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

Anesthesia Services We provide benefits 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 We provide benefits for approved asthma education programs for our covered members with asthma and their families. Benefits are provided for up to a calendar year maximum of \$200 per patient when the program is received from an approved network provider or professional. Please call us for a listing of approved providers and professionals.

Blood Transfusions We provide benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

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

Chiropractic Care We provide benefits for chiropractic care.

Christian Science Sanatorium We provide benefits for treatment in a Christian Science Sanatorium if the facility is operated by or listed and certified by the First Church of Christ in Boston. Only services for those admitted for healing, not for rest or spiritual refreshment, who are under the care of an authorized practitioner are covered. Charges of a Christian Science Sanatorium and/or practitioner must be incurred for a sickness or injury which would normally require treatment by a physician. Treatment must not be accompanied by any other medical treatment.

Clinical Trials We provide benefits for routine patient costs for items and services furnished in connection with participation in approved clinical trials. A member is eligible for coverage in an approved clinical trial if the following conditions are met:

- ♦ The member has a life-threatening illness for which no standard treatment is effective;
- ♦ The member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;
- ♦ The member's participation in the trial offers meaningful potential for significant clinical benefit; and
- ♦ The member's referring physician has concluded that the member'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 We provide benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis.

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

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

Dental Services We provide benefits 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 We provide benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by us.

Diagnostic Services We provide benefits 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.

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 Summary of Benefits for limits that apply. These terms apply to the following services:

Durable Medical Equipment We provide benefits 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 We provide benefits for prostheses. Prostheses include artificial limbs and prosthetic appliances. Please refer to the "Exclusions" section for additional information.

Emergency Room Care We provide benefits for emergency room treatment received for medical emergencies.

Family Planning We provide benefits for family planning. See the "Contraceptives" provision within this section for details.

Foot Care We provide benefits 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 We provide benefits for diagnostic services performed by freestanding imaging centers. All services must be ordered by a professional.

Home Health Care Services We provide benefits 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 us. Please see your Summary of Benefits for limits that apply.

We provide benefits 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.

Home Infusion Therapy We provide benefits for home infusion therapy when provided and billed by a Home Infusion Therapy provider. Supplies and equipment needed to appropriately administer home infusion therapy are covered.

Hospice Care Services We provide benefits for hospice care services furnished in your home by a home health agency to a member who is terminally ill and the member's family. A member 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.

We provide benefits 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 We provide benefits 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 We provide benefits for inpatient hospice care at an acute care hospital or skilled nursing facility. The same services are covered for inpatient hospice care as are covered under inpatient hospital services.

Inborn Errors of Metabolism We provide benefits for metabolic formula and up to \$3,000 per member per calendar year for special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by inborn errors of metabolism. This benefit is limited to those members with diseases caused by inborn errors of metabolism.

Independent Laboratories We provide benefits for diagnostic services performed by independent laboratories. All services must be ordered by a professional.

Inhalation Therapy We provide benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

Inpatient Hospital Services We provide benefits 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 Summary of Benefits;
- ♦ Your physician, hospital personnel, or we notify you that inpatient care no longer meets our guidelines for continued hospital admission.

Manipulative Therapy We provide benefits 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.

Medical Care We provide benefits for medical care and services including office visits and consultations, hospital and skilled nursing facility visits, and pediatric services.

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

Mental Health Services - Professional We provide benefits 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 Summary of Benefits for additional information regarding mental health benefits.

Mental Health and Substance Abuse Services - Provider We provide benefits 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.

We provide benefits 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 Summary of Benefits for additional information regarding mental health and substance abuse benefits.

Morbid Obesity We provide limited benefits 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.

Nursing Services We provide benefits for private duty nursing care outside a hospital. Care must be provided by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a nurse authorized by the First Church of Christ, Scientist Boston, MA, or a nurse midwife, if under the supervision of a physician and billed through a physician's office. You must call us at the number on the back of your ID card for prior approval.

Nutritional Counseling We provide benefits for nutritional counseling when required for a diagnosed medical condition. This benefit is limited to three visits per condition, but may be extended if authorized by your physician and us.

Obstetrical Services and Newborn Care We provide benefits 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 We provide benefits for office visits for certain care.

Organ and Tissue Transplants We provide benefits for organ and tissue transplant procedures listed below. You must receive prior approval from us before you are admitted for any transplant procedure. Your physician will work with our 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. We will not pay any benefits for any services related to a transplant we do not cover.

We provide benefits 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 We provide benefits for certain orthotic devices such as orthopedic braces, back or surgical corsets, splints, orthopedic shoes, arch supports, shoe inserts, abduction and rotation bars. We do 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 Services We provide benefits 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 us to see if you are eligible for benefits.

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

Physical and Occupational Therapy We provide benefits 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 Summary of Benefits 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 We provide benefits under your prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a hospital. This includes coverage of necessary supplies and equipment needed to appropriately administer medications, including clinically approved hyperalimentation supplies.

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 Anthem Prescription Management (APM). APM 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 about APM.

APM uses pre-approved criteria, developed by Anthem's Pharmacy and Therapeutics Committee and reviewed and adopted by Anthem BCBS. APM communicates the results of the decision to the pharmacist. APM 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 Certificate.

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 APM's website at www.anthemprescription.com. The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage.

We may determine, after consideration of recommendations from our Pharmacy and Therapeutics Committee, dispensing limitations for certain prescription drugs. Please call our Customer Service Department at the telephone number on your ID card for information on dispensing limitations.

Prescription Drugs From A Retail Pharmacy When your prescription is filled at a retail pharmacy, you pay the amount shown on your Summary of Benefits. 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 allows 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 or coinsurance amount indicated on your Summary of Benefits.

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. 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 Summary of Benefits for copayment amounts that apply to you.

Therapeutic Substitution of Drugs Your pharmacy benefit includes a therapeutic drug substitution program approved by Anthem BCBS and managed by APM. This is a voluntary program designed to inform members and physicians about formulary or generic alternatives to non-formulary and formulary brand drugs. APM may contact you and your prescribing physician to make you aware of formulary or generic drug substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your physician can determine whether the therapeutic substitute is appropriate for you. For a list of therapeutic drug substitutes that have been identified, contact a Customer Service Representative by calling the telephone number on the back of your ID card. You may also review the list of therapeutic drug substitutes on APM's website at: www.anthemprescription.com. The therapeutic drug substitutes list is subject to periodic review and amendment.

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.

Radiation Therapy We provide benefits for radiation therapy.

Reconstructive Services We provide benefits for reconstructive services, unless otherwise excluded in this contract, to improve or restore bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic process, or for congenital or developmental anomalies. Benefits are provided only when there is a functional impairment. 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.

Skilled Nursing and Rehabilitation The Plan covers skilled nursing facility care and rehabilitative therapy. Benefits are limited as follows:

- If you are transferred from a hospital to an eligible facility for care and treatment, coverage will be the same as normally received in a hospital. The Plan will cover two days of care in a skilled nursing facility for each day of hospitalization to a maximum of 730 days.
- If you have been discharged from a hospital, sent home, and then need to go to a skilled nursing facility, coverage is provided if confinement in the hospital was at least three consecutive days, and you enter the skilled nursing facility not more than 30 days after hospital discharge. The maximum benefit period is 100 days.

Smoking Cessation We provide benefits 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 up to two physician office visits per calendar year for follow-up smoking cessation education and counseling.
- ♦ We provide benefits for completing an approved smoking cessation program.

Please see your Summary of Benefits for applicable copayment, coinsurance, deductibles, limitations, and maximums that apply.

Speech Therapy We provide benefits 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 Summary of Benefits 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 Sterilizations and reverse sterilizations are covered.

Surgical Services We provide benefits for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care. We provide benefits for a surgical assistant when the complexity of the surgery warrants an assistant. We reserve the right to determine when surgical assistant services are required.

Temporomandibular Joint Syndrome Benefits are provided for treatment of temporomandibular joint syndrome and other craniomandibular disorders. These disorders include the following:

- ♦ Temporomandibular disc displacement with or without reduction;
- ♦ Dislocation of the temporomandibular disc;
- ♦ Capsulitis or synovitis of the temporomandibular joint;
- ♦ Osteoarthritis and/or osteoarthritis of the temporomandibular joint;
- ♦ Polyarthritides of the temporomandibular joint;
- ♦ Ankylosis of the temporomandibular joint;
- ♦ Myofascial pain of the muscles of mastication, myositis, spasm or trismus, protective muscle splinting, contracture, and tension-type headaches involving the jaw muscles.

Benefits are available in three categories: Diagnostic, Evaluative and Therapeutic. There are some specific exclusions in each.

The following diagnostic services are covered:

- ♦ Complete history and physical examination by the provider and/or upon consultation with a professional specializing in the diagnosis and treatment of TMD;
- ♦ Laboratory and/or diagnostic imaging and/or other recognized diagnostic tests when ordered by the treating professional to make a specific diagnosis.

Benefits are not provided for the following:

- ♦ Jaw tracking device;
- ♦ Occlusal analyzing devices;
- ♦ Surface electromyogram analysis.

The following evaluative services are covered:

- ♦ Tests or procedures designed to measure loss of normal function;
- ♦ Tests or procedures designed to evaluate the level of pain.

The following therapeutic services are covered:

- ♦ Therapeutic approaches designed to address the specific disorder identified;
- ♦ Supportive patient education;
- ♦ Pharmacologic pain control;
- ♦ Physical therapy modalities including moist heat, ultrasound, EMS, temporomandibular joint mobilization and distraction;
- ♦ Nocturnal flat plane stabilization splints designed and monitored by a professional approved by Blue Cross;
- ♦ Surgical removal of temporomandibular joint implants;
- ♦ Other invasive surgical procedures, only when conservative treatments have failed or when directed at specific organic diagnoses for which surgery is recommended treatment.

Benefits are not provided for the following therapies:

- ♦ Electromyogram feedback;
- ♦ Cranial-sacral therapy;
- ♦ Myofascial release therapy.

Well-Adult Preventive Services We provide benefits for the following well-adult preventive services for members age 18 and older:

- ♦ Routine doctor examinations, up to one exam each calendar year;
- ♦ Screening mammograms for women (benefits are limited to two radiographic views per breast);
- ♦ Screening Pap tests performed by a physician, certified nurse practitioner, or certified nurse midwife when recommended by a physician.
- ♦ Gynecological examinations, including routine pelvic and clinical breast examinations performed by a participating physician, certified nurse practitioner or certified nurse midwife;
- ♦ Prostate specific antigen testing and digital rectal examinations for men.

Please see your Summary of Benefits for limits that may apply.

Well-Baby Care We provide benefits for outpatient well-baby care from the date of birth and prior to the child's third birthday. Covered services include:

- ♦ Routine immunizations;
- ♦ Routine doctor examinations, up to six examinations in the first year of the child's life and up to two examinations through the second year;
- ♦ X-ray and laboratory services given or ordered during routine examinations that are related to the routine examination.

Well-Child Care We provide benefits for well-child care furnished from the child's third birthday up to the child's 18th birthday. Covered services include:

- ♦ Routine immunizations;
- ♦ Routine doctor examinations, up to one examination each calendar year;
- ♦ X-ray and laboratory services given or ordered during routine examinations that are related to the routine examination.

Section Four

Exclusions

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

Alternative Medicines or Complementary Medicines We do not provide benefits 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, biofeedback, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.

Artificial Hearts We do not provide benefits 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 We do not provide benefits 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.

Blood We do not provide benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

Cosmetic Services We do not provide benefits 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 We do not provide benefits for services, supplies or charges for Custodial Care, domiciliary or convalescent care, whether or not recommended or performed by a professional.

Dental Services We do not provide benefits 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 We do not provide benefits 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 We do not provide benefits 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.

Eye Examinations Routine eye examinations for vision correction are not covered.

Facilities of the Uniformed Services We do not provide benefits 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 We do not provide benefits for non-prescriptive birth control preparations (such as foams or jellies); over-the-counter contraceptive devices; and costs associated with achieving pregnancy through surrogacy.

Genetic Testing and Counseling We do not provide benefits for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition.

Government Institutions We do not provide benefits 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.

Hearing Care We do not provide benefits for hearing examinations except when related to injury or disease. Benefits are not provided for the prescription, fitting, or purchase of hearing aids including audiant bone conductors.

Infertility We do not provide benefits for diagnostic services, procedures, treatment or other services related to infertility. This exclusion also applies to drugs used to enhance fertility. We do not provide benefits for costs associated with achieving pregnancy through surrogacy.

Leased Services and Facilities We do not provide benefits 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 We do not provide benefits 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. We 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.

Medically Unnecessary Services We do not provide benefits for any treatment, services, or supplies that do not meet the definition of medically necessary health care.

Medicare We may not provide benefits 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, we 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, we 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 We do not provide benefits 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 We do not provide benefits 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 We do not provide benefits 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 We do not provide benefits for orthognathic surgery.

Orthotic Devices We do not provide benefits for orthotic devices unless stated as covered in the “Covered Services” section of this contract.

Personal Comfort Items We do not provide benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

Physical and Occupational Therapy We do not provide benefits 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 We do not provide benefits 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 We do not provide benefits for preventive care and well-care services, unless otherwise stated in the "Covered Services" section.

Prostheses We do not provide benefits 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 or contain a microprocessor.

Refractive Eye Surgery We do not provide benefits for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

Routine Foot Care We do not provide benefits for any services rendered as part of routine foot care. Please refer to the "Covered Services" section for foot care that is covered.

Services After Your Contract Ends We do not provide benefits 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 We do not provide benefits 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 We do not provide benefits for services provided by any provider or professional not listed as an eligible provider or professional in this contract.

Services by Relatives or Volunteers We do not provide benefits 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 We do not provide benefits for any service, procedure, or supply not listed as a covered service in this contract.

Services Related to Non-Covered Services We do not provide benefits for services related to any non-covered service or to any complications and conditions resulting from any non-covered service.

Sex Changes We do not provide benefits for any services related to any transsexual operation.

Speech Therapy We do not provide benefits 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.

Travel Expenses We do not provide benefits for any travel expenses, whether or not the travel is recommended by a professional.

Vision Care We do not provide benefits 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.

Weight Reduction Programs We do not provide benefits for weight reduction programs other than those described in the “Morbid Obesity” provision of the “Covered Services” section.

Workers’ Compensation We do not provide benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers’ Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide benefits if you are entitled under the applicable workers’ compensation law to waive all workers’ compensation coverage, and do so before the condition, ailment, or injury occurs. We will pay benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met:**

- ♦ You are making a claim under the Workers’ Compensation Act;
- ♦ Your health care coverage is provided through an employee health plan;
- ♦ Your employer or your employer’s workers’ compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- ♦ The Workers’ Compensation Board has not made a determination on your claim;
- ♦ Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers’ Compensation Act, you should also submit your claims under this plan, as discussed in the “Benefit Determinations, Payments and Appeals” section.

Section Five

Benefit Determinations, Payments and Appeals

Benefit Determinations

We, 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. Our 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 our 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 contract. Your responsibility may take the form of a coinsurance percentage, a deductible, or a copayment amount. Please see your Summary of Benefits 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 our Maximum Allowance for professionals. **Note:** We 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 our Maximum Allowance for professional services.

We 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, behavioral 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.

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

Network Providers If your claim from a network provider is approved, we will pay benefits directly to the network provider. Except for copayments, you are not required to pay any balances to the provider for covered services until after we determine the benefits we will pay. Benefits will be paid at the network level of benefits listed on your Summary of Benefits.

Non-Network Providers If you receive covered services or supplies from a provider that does not have a written agreement with us, we will determine benefits based on the provider's eligibility and licensing. If we do approve your claim, you will be responsible for the difference between the non-network provider's charge and our Maximum Allowance amount, in addition to any applicable copayment or deductible. We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and our Maximum Allowance.

If a network provider of the same specialty is not reasonably accessible, as defined by state law, services received from a non-network provider will be paid at the higher level of benefits indicated on your Summary of Benefits. In this circumstance, please call the number on the back of your ID card to coordinate care through a non-network provider.

How Your Deductible Works

Each calendar year before benefits can be paid for most covered services, you must pay your deductible. The deductible is the amount you must pay toward the cost of covered services before benefits are paid.

A separate deductible must be met for medical services and non-listed mental health services. Please refer to your Summary of Benefits for the deductible amount that applies.

When you receive covered services during the last three months of the calendar year and charges for these covered services are applied toward that year's deductible, then these same charges will also be applied toward the deductible for the following year.

Family Deductible Under family coverage, if the total family expenses for covered services exceed two times the individual deductible, then your family deductible 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 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.

The deductible does not apply to certain services, such as medications purchased under the prescription drug card program. Please see your Summary of Benefits.

Copayments and Coinsurance

Copayments and coinsurance apply after you have satisfied your deductible. Please see your Summary of Benefits for copayment amounts and coinsurance amounts and limits. If services are received from a provider that does not have a written participation agreement with us 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. We 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 or a percentage. Copayment amounts do not count toward any coinsurance limits under this contract.

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. Once you pay the annual coinsurance limit, we pay benefits at 100% of the Maximum Allowance for covered services, (except non-listed mental health services) up to the lifetime maximum for the rest of the calendar year.

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.

Out-of-Pocket Limits

Your annual out-of-pocket expenses for your deductible and coinsurance are limited. Please refer to your Summary of Benefits for annual out-of-pocket limits that apply. Once you reach the annual out-of-pocket limit, no further deductibles or coinsurance apply for the remainder of the calendar year (except for non-listed mental health and substance abuse deductibles and coinsurance). Copayment amounts continue to apply after the annual out-of-pocket limits are met.

Lifetime Maximums

Your contract has a limit on the maximum amount for which we are responsible during the lifetime of any covered member. The amount of the lifetime maximum is stated on your Summary of Benefits. All benefit amounts for which we are responsible, over and above your copayments or coinsurance payments, are accumulated toward your lifetime maximum under your contract. Once benefit amounts equal to the lifetime maximum have been accumulated, we will not be liable for any further payments for covered services you incur.

Once your lifetime maximum benefit has been met, you may be eligible for additional benefits of up to \$1,000 each calendar year, if we receive proof of your good health. This proof must be satisfactory to us. Benefit restoration does not apply to non-listed mental illnesses, substance abuse services or temporomandibular joint syndrome (TMJ).

Benefit Maximums

Specific benefit maximums for each covered member may apply for mental health and other services. These maximums are listed on your Summary of Benefits or in the contract.

Contract Changes

We may change this contract at any time provided the changes are in accordance with all applicable laws and we give the group notice thirty days in advance. After we notify the group of a change, payment of billed charges indicates the group's and your acceptance of the change. The group is responsible for notifying the employee of any contract changes.

Compliance with Laws

If federal laws or the relevant laws of the state of Maine change, the provisions of this contract 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. We may use or disclose this information only to the extent required or permitted by law. Please refer to Anthem BCBS's privacy protection annual notice for our privacy policies and procedures.

Statements and Representations

The statements you make on your application for coverage with us are representations and not warranties.

Annual Reports

Annual reports are prepared and made available to all employees. The annual report contains information about our activities including audited financial statements.

Severability

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

Benefit Payments

Claims Procedure

How to Claim Benefits In most instances, providers and professionals will file your claims with us. However, you may need to submit a claim for reimbursement for services from non-network providers and professionals.

To receive claim forms, contact your employer or call our 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 We must receive proof of a claim for reimbursement for a covered service no later than 15 months after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 15-month limit. Claims denied for timely filing may be reviewed through the member appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information Providers and professionals often have information we need to determine your coverage. As a condition for receiving benefits under this contract, you or your representative must give us 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 we do not enforce compliance with any provision of this contract, we have not waived compliance and are 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, we may require the member to have a physical or mental examination at our expense.

Claims Payment

This section explains how benefits for covered services will be paid. You will receive maximum benefits when you receive services from network providers and professionals. We reserve 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.

Payment of Provider Services

Network Providers If your claim from a network provider is approved, benefits will be paid directly to the provider. Our payment will be based on the most cost effective means that can be safely administered. Except for deductibles, you are not required to pay any balances to the provider until after we determine the benefits we will pay. Network providers who render covered services that are based on a Maximum Allowance agree to limit their charges to the Maximum Allowance.

Non-Network Providers If you receive covered services or supplies from a provider that does not have a written participation agreement with us, we will decide if we will pay benefits. We will base this decision on factors such as the provider's ability to meet certain standards for licensure and expertise to meet the needs of the member. Our payment will be based on the most cost effective means that can be safely administered. If we do approve your claim, benefits will be paid directly to you or the provider. We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and our Maximum Allowance.

Payment for Professional Services

Network Professionals If your claim from a network professional is approved, benefits will be paid directly to the professional. Our payment will be based on the most cost effective means that can be safely administered. Except for deductibles, you are not required to pay any balances to the professional until after we determine the benefits we will pay. Network professionals who render covered services that are based on a Maximum Allowance agree to limit their charges to the Maximum Allowance unless you and the professional make prior arrangements.

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 us.

Non-Network Professionals If you receive covered services or supplies from a professional that does not have a written agreement with us, we will decide if we will pay benefits. We will base this decision on factors such as the professional's ability to meet certain standards for licensure and expertise to meet the needs of the member. Our payment will be based on the most cost effective means that can be safely administered. If we do approve your claim, benefits will be paid directly to you or the professional. We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and our Maximum Allowance.

Provider and Professional Payment Methods

We generally pay specialists and professionals for each covered service they provide, based on a Maximum Allowance. The Maximum Allowance for a service is determined based upon the resources needed to provide a given service. The resources taken into account are a professional's total work, practice costs, and malpractice costs which are added together. The total is multiplied by a common scale monetary conversion factor to establish the Maximum Allowance. Our payment will be based on the most cost effective means that can safely be administered. You can contact us to find out the Maximum Allowance for a service by calling the telephone number on your ID card.

We generally pay providers in several different ways. These ways may include discounts from regular charges and fixed fees.

Out-of-State Providers and Professionals We cannot prohibit out-of-state providers from billing you any balance remaining after we have made our payment based on the maximum allowable amount, except as otherwise provided under the BlueCard program.

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 us.

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 member 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 member liability calculation methods that differ from the method outlined above, we 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 We provide benefits for inpatient and outpatient services in a foreign hospital. If you obtain covered services outside of the United States, in most cases you will have to pay your bill when you leave the hospital. Please refer to the “Utilization Management” section for details pertaining to authorizations.

When you return home, send the following to us with your claim form:

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

When we receive this information, we will reimburse you for covered services according to the terms of this contract.

Anthem Prescription Management (APM)

The pharmacy benefits available to you under this Plan are managed by our affiliate, Anthem Prescription Management (APM). APM is a pharmacy benefits management (PBM) company with which we contract to manage your pharmacy benefits. APM has a nationwide network of retail pharmacies, a mail service pharmacy, and clinical services that include formulary management.

The management and other services APM provides include, among others, making recommendations to, and updating, the formulary and managing a network of retail pharmacies and operating a mail service pharmacy. APM, in consultation with Anthem BCBS, 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 APM, in this or any other state. You must pay the applicable copayment amounts shown on your Summary of Benefits. The participating pharmacy will submit the claim for you and APM 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 APM, 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 to APM 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.

Prescription Drugs By Mail To obtain benefits for prescription drugs through 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 Summary of Benefits.

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.

Coordination of Benefits

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

COB sets the payment responsibilities for any contract that covers you, such as:

- ♦ Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- ♦ Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- ♦ Other insurance that provides medical benefits.

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

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 section;
- ♦ Exchange information with an insurance company or other party;
- ♦ Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- ♦ Take these actions when we decide they're necessary without notifying the covered persons.

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 illness 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.

If You Qualify For Medicare

Active Employees If you or your eligible dependent becomes eligible for Medicare while you are still actively at work, your medical benefits will be provided primarily by the University Plan. Medicare will be a secondary benefits payor.

Medicare may supplement the payments you receive from this Plan. However, these supplementary Medicare payments will be limited so that the combined benefits paid will not be more than the expenses your or your dependent have incurred. You must notify Anthem BCBS if you become eligible for premium-free Medicare Part A. Failure to notify Anthem BCBS could result in cancellation of your coverage.

You may choose to continue your coverage once you are eligible for premium-free Medicare Part A. However, your CompCare Comprehensive group health plan 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 Part A coverage.

For you and your dependents who are eligible for Medicare because of renal failure, this Plan is considered the primary payor for the first 18 months after your Medicare effective date. After the 18-month period, this Plan will become the secondary payor and Medicare will become the primary payor.

Retirees Retirees enrolled in this Plan who are enrolled in Medicare Parts A and B are subject to CompCare Medicare coordination of benefits. The retiree-subscriber files all claims with Medicare first. Medicare is the primary payor.

After Medicare determines its benefits, the retiree-subscriber files a copy of the Explanation of Medicare Benefits (EOMB) to Anthem BCBS under the CompCare certificate number. Anthem BCBS will pay balances for covered services according to the terms of the CompCare comprehensive group health plan. The CompCare comprehensive group health plan deductible, coinsurance, maximums, and all other terms apply.

Subrogation: Payments Resulting from Claim or Legal Action

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

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

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

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

By accepting plan coverage you agree:

- ♦ Your signed application for coverage is your authorization of our right of subrogation;
- ♦ To notify us of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- ♦ To notify us of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;

- ♦ To cooperate with us in exercising our right of subrogation by providing all information requested;
- ♦ To sign documents we deem necessary to protect our rights; and
- ♦ To do nothing to interfere with our subrogation rights.

If you do not comply with the above, you may be responsible for expenses we incur in enforcing our subrogation rights.

Complaints and Appeals

Complaints

Our Customer Service Representatives are available to assist members 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 member complaint will conduct an investigation and promptly issue a decision to the member 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 our 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, we 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, we will promptly notify the member 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 us.

Appeals

Level One Appeal Process

You or your authorized representative, if dissatisfied with our initial decision or the decision on a registered complaint, may appeal the decision to the Appeals Department at Anthem BCBS. 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. We reserve 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.

Your authorized representative includes a person to whom you have given express written consent to represent you in an external review; a person authorized by law to provide consent to request an external review for you; or a family member or your treating health care provider when you are unable to provide consent to request an external review.

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 member, 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 member, or member representative, if dissatisfied with the outcome, may submit a voluntary second level appeal to Anthem BCBS, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000**.

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 Anthem BCBS. 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. Anthem BCBS 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 member, any treating professional, or Anthem BCBS. **You or your authorized representative, may appear before the review panel.** The review will be conducted within forty-five (45) working days of receipt of the member's Level Two Appeal. A written decision will be issued to the member within five (5) working days of completing the review. Once a final decision has been issued by the Second Level Appeal panel, the member may request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000**.

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 Anthem BCBS

No legal action may be brought against Anthem BCBS until the member or the member'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 notice.

Section Six Definitions

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

Accident Care Treatment of a traumatic bodily injury resulting from an accident.

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 our standards for participation.

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

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 members may also terminate enrollment. Members 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. After you meet an annual out-of-pocket limit, you pay no further deductible or coinsurance for most services. Copayments still apply. Coinsurance you pay for non-listed mental health services and substance abuse services does not count toward your annual limit. Once your out-of-pocket limit is met, you continue to pay coinsurance for these services.

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

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

Benefits Payments we make on your behalf under this contract.

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.

Certificate The document that specifies the health care benefits available to members under this contract.

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

Coinsurance The percentage we pay 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 our standards for participation.

Contract This Certificate, any amendments, riders, or attached papers; the Group Agreement; your application; and the Summary of Benefits.

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

Copayment A fixed dollar amount or percentage required to be paid by each member for certain covered services under this contract. Please refer to your Summary of Benefits 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 Certificate. To be a covered service the service, supply or treatment must be:

- a. Medically necessary or otherwise specifically included as a benefit under this Certificate.
- b. Within the scope of the license of the professional performing the service.
- c. Rendered while coverage under this Certificate is in force.
- d. Not experimental or investigational or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
- e. Authorized in advance by us if such preauthorization is required in this Certificate.

Creditable 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 or the Peace Corps health benefit 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 coverage.

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 contract 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 Certificate. 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 we have negotiated with hospitals and other providers. Members benefit from these rates or discounts since they are applied prior to calculating your share of costs. Discounted charges reduce the expenses paid by us 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 member'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.

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 member'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 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 conclusory concerning the effect of the service on health outcomes;
 - (ii) Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
 - (iii) Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
 - (iv) Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

- (c) The information considered or evaluated by Anthem 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 and Medical Leave Leave granted a subscriber 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 our 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 our 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 our 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 applies for and accepts this coverage on behalf of its members. 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 our standards for participation.

Hospice A facility that meets both of the following requirements:

- ♦ Licensed as a hospice; and
- ♦ Meets our 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 our 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.

Insurer Administrator Anthem Blue Cross and Blue Shield.

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 member'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 we will pay for a covered service based on our contracts with providers and professionals. Our payment will be based on the most cost effective services that can be safely administered.

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 member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

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

Medicare Title XVIII of the United States Social Security Act, Medical Care for the Aged and Disabled.

Member The subscriber and all family members who are eligible for coverage and who we accept for coverage under this contract.

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 Metropolitan Life Insurance table.

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.

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.

Our See definition of “We, Us, or Our.”

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.

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 Our 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 Insurer Administrator and the University as the Contract Holder/Sponsor.

Plan Anniversary Date The date occurring in each calendar year which is an anniversary of the effective date of the Plan. The anniversary date is January 1.

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.

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 Acupuncturists
- ♦ Licensed Audiologist
- ♦ Licensed Psychiatric Nurse Specialist
- ♦ Licensed Clinical Social Worker
- ♦ Physical Therapist
- ♦ Occupational Therapist
- ♦ Speech Therapist
- ♦ Registered Nurse
- ♦ Licensed Practical Nurse
- ♦ Licensed Clinical Professional Counselors
- ♦ Certified Nurse Midwife
- ♦ Ambulance Services
- ♦ Christian Science Practitioners listed as accredited in the current Christian Science Journal
- ♦ 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
- ♦ Home Infusion Providers
- ♦ Facilities operated by or listed and certified by the First Church of Christ, Scientist in Boston
- ♦ 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.

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 our standards for participation.

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 our standards for participation.

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

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 applied for coverage under this contract and whose application and payment of required subscription charges we have accepted.

Subscription Charge The rates established by us as consideration for benefits offered in this contract.

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 our 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 us 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.

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.

Us See definition of “We, Us, or Our.”

Utilization Management The process we use 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 group or us before enrollment in this group health plan is allowed.

We, Us, or Our Anthem Blue Cross and Blue Shield and its designated affiliates.

You or Your The employee or retiree and all dependents whom we accept for coverage under this contract.

Section Seven

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 10 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 Eight

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 inquires 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 Nine

ERISA Rights

The University of Maine System has established this Plan for the benefit of its employees. The provisions of the Employee Retirement Income Security Act of 1974 (ERISA) do not apply to this Plan.

The University of Maine System anticipates that this Plan is established as a permanent health and welfare benefit plan. The University of Maine System, however, reserves the right to amend, modify, or terminate the Plan, or any part of the Plan, by written instrument executed by the University of Maine System. Upon execution, such instrument will become effective in accordance with its terms to all Plan participants and all persons having or claiming any interest hereunder.

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