# HEALTHCHOICE PLUS

# CERTIFICATE OF COVERAGE

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

# Introduction

This Certificate contains information that you need to know about your Individual Preferred Provider Organization (PPO) coverage from Anthem Blue Cross and Blue Shield (Anthem). You are urged to read this Certificate of Coverage carefully.

The terms WE, US and OUR in this Contract refer to Anthem Blue Cross and Blue Shield and its designated affiliates. When we use the term YOU or YOUR, we are talking about the Subscriber and all Dependents whom we accept for coverage under this Contract.

This Certificate of Coverage explains how your HealthChoice Plus 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 will base all decisions on the provisions in this Certificate of Coverage.

Paying your HealthChoice Plus Subscription Charges.

When choosing to purchase HealthChoice Plus, you may elect to be billed for your subscription charges monthly or quarterly. Payment for subscription charges is due the first day of each month, or the first day of each quarter of coverage. You have a grace period of 31 days to pay the subscription charges, during which you will not experience 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 subscription charges for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.. Written notice of subscription charges will be provided 60 days prior to effective date of the increase.

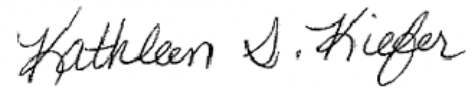
Renewing your HealthChoice Plus Coverage.

When you pay your HealthChoice Plus subscription charges, as described above, your coverage renews. Periodically, you subscription charges may change, subject to approval by the Bureau of Insurance. When this occurs, you will receive written notification from us, advising you of the new subscription charges and the effective date the change will occur. The change in your subscription charges will appear on your next bill. It is important to note that if you pay your subscription charges quarterly and the effective date for the change has already been billed to you, the additional subscription charges due for that quarter will be included on your next bill. Written notice of subscription charges will be provided 60 days prior to effective date of the increase.

**10 Day Certificate Review**

The Certificate of Coverage, any amendments or attached papers, and your individual application (including Health History Statement) make up your Contract and your complete coverage with Anthem for health care Benefits. This Certificate of Coverage replaces any previous Certificates of Coverage you may have received. Services provided during an inpatient stay that started during an existing Contract will continue to be covered by the terms of that Contract until you are discharged or reach any of the Contract's limits or maximums, whichever occurs first.

If you decide not to accept this Certificate, return it to our home office (Anthem Blue Cross and Blue Shield; 2 Gannett Drive; South Portland, ME 04106-6911) within 10 days after its delivery date. Please include a written request to cancel it. We will then refund any subscription charges you've paid for this Contract.



Kathleen S. Kiefer
Corporate Secretary

# TABLE OF CONTENTS

**SECTION ONE - ELIGIBILITY AND TERMINATION OF COVERAGE** ..... 6

**SECTION TWO - UTILIZATION MANAGEMENT** ..... 12

**SECTION THREE - COVERED SERVICES** ..... 15

**SECTION FOUR - EXCLUSIONS** ..... 28

**SECTION FIVE - BENEFIT DETERMINATIONS, PAYMENTS AND APPEALS** ..... 35

**SECTION SIX - DEFINITIONS** ..... 51

## 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.

# Section One - Eligibility and Termination of Coverage

## Beginning Coverage

Before your coverage begins we must accept your application and payment for your coverage. Payment is due the first day of the month for that month's coverage.

Paying your HealthChoice Plus Subscription Charges.

When choosing to purchase HealthChoice Plus, you may elect to be billed for your subscription charges monthly or quarterly. Payment for subscription charges is due the first day of each month, or the first day of each quarter of coverage. You have a grace period of 31 days to pay the subscription charges, during which you will not experience 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 subscription charges for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws. Written notice of subscription charges will be provided 60 days prior to effective date of the increase.
Renewing your HealthChoice Plus Coverage.

When you pay your HealthChoice Plus subscription charges, as described above, your coverage renews. Periodically, you subscription charges may change, subject to approval by the Bureau of Insurance. When this occurs, you will receive written notification from us, advising you of the new subscription charges and the effective date the change will occur. The change in your subscription charges will appear on your next bill. It is important to note that if you pay your subscription charges quarterly and the effective date for the change has already been billed to you, the additional subscription charges due for that quarter will be included on your next bill. Written notice of subscription charges will be provided 60 days prior to effective date of the increase.

## Who is an Eligible Individual Member?

1. The Subscriber;
2. The Subscriber's legal spouse;
3. The Subscriber's/spouse's child under age 26, including (a) newborn children; (b) biological children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the subscriber; when that child:
   (i) has no dependent of the child's own;
4. The Subscriber's/spouse's child who is mentally or physically disabled. The disability must have begun before the child's 26th birthday, and the child must have been covered by us on and continuously since his or her 26th birthday.

We will determine the effective date of coverage for the Subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call us.

We reserve the right to verify continued eligibility for all Members.

**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.

## Continuity of Coverage

If you or any covered family member had prior creditable coverage, within 90 days of the effective date of this Contract, we will waive pre-existing condition restrictions to the extent that Benefits would have been payable under your prior Contract or government program if that Contract or government program were still in effect. Even when pre-existing condition restrictions have been to some extent waived, we will only provide Benefits that are described in this Certificate regardless of whether they would be available under your prior Contract or government program.

Federally Eligible Individuals with an effective date of coverage under this Contract on or after 1/1/98 will have all pre-existing condition restrictions waived. (For the definition of "Federally Eligible Individual" please refer to the Definition section.)

An individual seeking to reduce or eliminate a pre-existing condition limitation period based on his/her prior creditable coverage may do so by providing a Certificate of Creditable Coverage to us. We will assist in obtaining a Certificate from any prior plan or issuer, if necessary.

Membership Additions
If you wish to add eligible family members after we have accepted your application, you must:

- File an application and Health History Statement; and
- Pay the applicable subscription charge.

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage.

Family members who are eligible because of birth, adoption, marriage, court order, or dependent losing eligibility under the other coverage after the Subscriber's effective date of coverage may be added as follows:

**Dependent Losing Eligibility Under Other Coverage** When a dependent with other coverage loses that coverage, if we receive the application for change:

- **Within 31 days of the date the dependent loses coverage,** coverage will begin on the date of application for enrollment. Coverage may be issued subject to Pre-existing Condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusions section and the "Continuity of Coverage" paragraph in this section. Coverage begins on the first of the month after we accept the application and receive the applicable charges.

**Birth** A newborn is automatically covered for 31 days from the moment of its birth unless the Subscriber notifies us that the child will not be covered under the Contract. For coverage beyond 31 days, if we receive a completed application for change:

- **Within 31 days from the date of birth**, coverage is continuous from the moment of birth. We will collect applicable charges.
- **After 31 days from the date of birth,** coverage begins on the first of the month after we accept the application and receive the applicable charges.

**Adoption** If we receive an adopted child's application for change:

- **Within 31 days from the date the child is adopted or placed for adoption with the Subscriber and/or spouse**, coverage will begin on the date of placement. We will collect applicable charges. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply.
- **After 31 days from the date the child is adopted or placed for adoption** with the Subscriber and/or spouse, coverage begins on the first of the month after we accept the application and we receive the applicable charges.

**Court Order Changing Custody** When a court order is issued changing custody of a dependent child, if we receive the application for change:

- **Within 31 days of the date of the court order**, coverage will begin on the date of the court order.
- **After 31 days from the date of the court order,** coverage begins on the first of the month after we accept the application and receive the applicable charges.

**Marriage** When the Subscriber marries, if we receive the spouse's (and children's, if applicable) completed application for change:

- **Within 31 days from the date of marriage**, coverage begins the first of the month that occurs immediately on or after the date we receive the application.
- **After 31 days from the date of marriage**, coverage may be issued subject to Pre-existing Condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusions section and the "Continuity of Coverage" paragraph in this section. Coverage begins on the first of the month after we accept the application and receive the applicable charges.

**Domestic Partners** If we receive a completed application for change:
Coverage begins on the first day of the month that occurs immediately on or after the date we receive the application and premium payment. Coverage may be issued subject to Pre-existing Condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusions section and the "Continuity of Coverage" paragraph in this section.

**Pre-existing Condition Limitation for Members age 19 and older** The pre-existing condition exclusion will not apply to conditions discovered through genetic testing that have not manifested as conditions requiring treatment; to newborns who are enrolled by the thirty-first day after birth or who are covered by prior creditable coverage; or to a child who is adopted or placed for adoption and who is enrolled by the thirty-first day after adoption or being placed for adoption or who are covered by prior creditable coverage.

An individual seeking to reduce or eliminate a Pre-existing Condition limitation period based on his/her prior Creditable Coverage may do so by providing a Certificate of Creditable Coverage or proof of prior coverage to us. We will assist in obtaining a certificate from any prior plan or issuer, if necessary.

For the purpose of identifying a pre-existing condition, claims submitted with a total provider charge under $1,000 (the threshold), are generally not subject to review. Any claim(s) submitted in excess of the threshold, for Members with pre-existing condition exclusions, may be reviewed to determine if the condition is pre-existing. Once a pre-existing condition has been established, all subsequent claims, regardless of provider charge amount, may be subject to review. As Anthem may apply a threshold in its claims review, the payment of claims with a charge amount below the threshold should not be relied upon as a representation that future claims related to the condition will be paid.

# Termination of Coverage

The subscriber 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 Member's Contract

**Ending Eligibility** If the Subscriber ends membership, or if you cease to meet the definition of eligible, as described in this section, your coverage will be canceled. We reserve the right to verify your initial and continued eligibility.

**Deletion from Membership** If 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, or a member's death. The subscriber must notify us 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 reach age 26 Coverage will end on the last day of the month immediately on or after your 26th birthday.
- You cease to meet the definition of an eligible Dependent.

**No Longer Residing or Working in Maine** Your coverage will end if you no longer reside or work in Maine for at least 6 months per year. You must notify us if you fail to reside or work in Maine for at least 6 months per year.

**Non-Payment of Charges** Your Contract will be canceled for non-payment of subscription charges by the due date. However, if we receive payment within the grace period, your Contract will remain in effect. We will not allow reinstatement once the grace period has ended.

**Misrepresentation or Fraud** Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination of that Member's coverage 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. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination of that Member's coverage

**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.

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 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 cognitive impairment or functional incapacity at the time of cancellation. For the purposes of this provision, cognitive impairment or functional incapacity means a mental or nervous disorder of demonstrable origin that causes significant impairment.

If you request reinstatement, we may require a physician examination at your own expense or request medical records that confirm you suffered from cognitive impairment or functional incapacity 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 within 15 days from our request.. 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 will give you a written record of the coverage you received under the Contract, and the waiting period, if any. You will receive a Certificate of creditable coverage when your coverage ends, and upon your request (if the request is made within 24 months following termination of coverage). You may need to submit the Certificate of Creditable Coverage to reduce the duration of any subsequent Pre-existing Condition limit, if there is one, by one day for each day of prior coverage (subject to certain requirements).

# 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 and determine if you are receiving medically necessary inpatient and outpatient 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 financial 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 Medical Policy

The purpose of medical policy is to assist in the interpretation of Medical Necessity. However, the Certificate of Coverage takes 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.

## 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 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 preadmission 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.

**Post-Admission Review** All inpatient admissions for emergency 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. 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 at the higher benefit level only until we determine that your condition reasonably permits your transfer to a participating hospital or other participating health care facility. If you choose not to be moved once your condition permits, Benefits will be provided at the lower benefit level from that point forward.

For emergency 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.

**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 and 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.

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 as outlined in the "Covered Services" section.

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

**Inpatient Mental Health/Substance Abuse Review** Authorization for 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 prior 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 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.

## Second Surgical Opinion

A second surgical opinion is an opinion given by a network board certified surgeon when your doctor recommends surgery. It is important to note that although you may receive a second surgical opinion, the choice of having the surgery is always yours.

To receive Benefits for a second surgical opinion, you must receive approval from us prior to seeking the second surgical opinion. We pay up to the Maximum Allowable Amount for second surgical opinions. Deductibles and Coinsurance do not apply to this benefit.

For approval of a second surgical opinion, call toll-free customer service number on the back of your ID card.

## Network Provider Unavailable

If you are unable to obtain services from a Network Provider, you or your doctor should call the telephone number on your ID card. Our care managers will work with you or your doctor to locate a Network Provider. If it is determined by the care manager that no Network Provider is available, we will authorize Covered Services from a Non-Network Provider. Benefits will be reimbursed at the higher network level with no balance billing.

# 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, maximums, exclusions, limitations, terms, provisions and conditions of this Contract, including any attachments and amendments or riders. Benefits for Covered Services are based on the Maximum Allowable Amount. To receive maximum Benefits for Covered Services, you must follow the terms of the Certificate, including, use of Network Providers and obtaining any required prior authorization.

Our payment for Covered Services will be limited by any applicable Deductible or annual maximum. Please see the "Utilization Management" section for conditions that apply to all inpatient admissions.

Benefits for Covered Services may be payable subject to an approved treatment plan. Only medically necessary health 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 bases its decisions about referrals, prior authorization, medical necessity, experimental services and new technology on medical policy developed by Anthem. Anthem 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 Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in the "Utilization Management" section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

**Allergy Testing and Injections** 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 when the program is received from an approved Network Provider. Please call us for a listing of approved Providers.

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

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

**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. See the "Manipulative Therapy" provision for additional information.

**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.

**Complications of Pregnancy.** We do provide benefits for complications of pregnancy.

**Contraceptives** We provide Benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) and on our Generic based Formulary to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis. Contraceptives are covered under the Preventive Benefit. Please see the Preventive and Well-Care Services section in this Certificate.

**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 (but not a root cyst)
- Treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later
- Repairing or replacing dental prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.

**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 contact.

You must receive prior authorization from us for the advanced diagnostic imaging services which include but are not limited to:

CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

**Durable Medical Equipment and Prostheses** If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, Benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs.

**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. Prostheses to replace limbs (ie: arms or legs) are not subject to the plan Deductible. All other prostheses are subject to the Deductible. Coverage for repair and replacement if the repair or replacement of the prostheses is determined appropriate by the enrollee's Provider . Please refer to the "Exclusions" section for additional information.

**Early Intervention Services** We provide benefits for early intervention services for Members from birth to age 36 months with an identified developmental disability or delay. A referral from the Child's primary care provider is required. Please refer to your Summary of Benefits for Cost-Shares and Limits.

**Emergency Room Care** We provide Benefits for emergency room treatment received for medical emergencies. You or a designated person should contact your physician within 48 hours from the time you receive care.

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

**Foot Care** We provide Benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

**Freestanding Imaging Centers** We provide Benefits for diagnostic services performed by freestanding imaging centers. All services must be ordered by a professional. You must receive prior authorization from us for the advanced diagnostic imaging services which include but are not limited to:

CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

**Hearing Care** We provide benefits for wearable hearing aids for covered Members up to age 18. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing. Please see your Summary of Benefits for Cost-Shares and Limits.

**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 Cost-Shares and Limits.

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. Respite care is intended to allow the person who regularly assists the patient at home, either a family member of 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 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.

**Infant Formula** We provide Benefits for Medically Necessary Amino Acid-based elemental Infant Formula for children 2 years of age and under. Benefits are provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

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

Benefits for amino acid-based elemental infant formula are provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A subsection 10-A, that the amino acid based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing Medical Necessity at least annually.

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

Prior Authorization is required. Please see the "Utilization Management" section of this document for more information.

**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. Please see your Summary of Benefits for Cost-Shares and Limits.;
- 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;

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 Contract limits or maximums;
- 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 therapeutic adjustments and manipulations 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. Please see your Summary of Benefits for Cost-Shares and Limits.

**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 and Substance Abuse Services** 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.

The "Utilization Management" section contains additional information and requirements for mental health and substance abuse services. If you do not call for preadmission review for nonemergency inpatient mental health and substance abuse services, your Benefits will be reduced by as much as $500 per admission.

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, or licensed clinical social worker; 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.
- Intervention and assessment.

Listed Mental Illnesses: State of Maine Statute requires that benefits be provided at the same benefit level provided for medical treatment for the following listed mental illnesses: Psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.

Please see your Summary of Benefits for Cost-Shares and Limits for inpatient, outpatient and office visits for mental health and substance abuse services.

**Office Visits** We provide Benefits for office visits.

**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, and splints. We do not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

**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 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.

**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 the Pharmacy Benefit Manager (PBM). PBM is a pharmacy benefit management company with which we contract to manage your pharmacy Benefits. Please see the "Benefit Determinations, Payments and Appeals" section for additional information about PBM.

PBM uses pre-approved criteria, developed by Anthem's Pharmacy and Therapeutics Committee and reviewed and adopted by Anthem. PBM may contact your prescribing physician if additional information is

required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to Appeal through the Appeals process outlined in the "Benefit Determinations, Payments and Appeals" section of this Certificate.

We only cover the drugs listed on Anthem's Prescription Drug list. Our prescription plan is a Generics-based Formulary that has some Brand Name Drugs too. We review and add drugs to the Prescription Drug list every so often. We can take a drug off Our list or move it to another tier.

If brand name drug is purchased when generic was available, the member pays the difference between the brand and generic.

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 PBM's website at **www.anthem.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.

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

We may determine, after consideration of recommendations from our Pharmacy & 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 pharmacy the Coinsurance amount stated on your Summary of Benefits plus any Deductible amount. Your prescription Deductible is separate from your medical Deductible.

**Prescription Drugs From A Non-Network Pharmacy** If You get drugs from an Non-Network Pharmacy, You must pay the pharmacy the entire cost for the prescription and submit a claim form to PBM 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.

NOTE: Please refer to the claims payment section of this Certificate for information on The Pharmacy Benefits Manager (PBM).

**Prescription Drugs By Mail** Your Contract may allow you to obtain prescription drugs by mail. To obtain Benefits for prescription drugs by mail, complete a mail order pharmacy form, available through our Customer Services Department, and mail it with your prescription. Please call the telephone number on the mail order pharmacy form to speak with a representative regarding the amount to include with your order.

**Prescription Supplies** Benefits are provided for up to a 90-day supply if prescribed by your physician as medically appropriate.

**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 (based on the dosage schedule prescribed by the physician) or within 10 days of the refill date, whichever is greater. We will not provide Benefits for refills that are filled sooner.

**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.

**Prescription Drug Continuity** If you have been undergoing a course of treatment with a prescription drug that has been prior authorized by your prior carrier, you may continue with that prescription drug until we conduct a review of the prior authorization with your Provider. Anthem has the right to request a review with your prescribing Provider. We will honor the prior carrier's prior authorization for a period up to 6 months if your Provider participates in the review and requests the prior authorization be continued. We are not required to provide benefits for conditions or services not otherwise covered under our Contract, and cost sharing may be based on the copayments and coinsurance requirements of this Contract.

Please see your Summary of Benefits for Cost-Shares and Limits.

**Preventive and Well-Care Services** We provide Benefits for the following preventive and well-care services. Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member as explained in your Certificate. That means Anthem pays 100% of the Maximum Allowed Amount. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's charge unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.

These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.
   Examples of these services are screenings for:
   Breast cancer;
   Cervical cancer;
   Colorectal cancer;
   High Blood Pressure;
   Type 2 Diabetes Mellitus;
   Cholesterol;
   Child and Adult Obesity;
   Gestational diabetes screenings.

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

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration including:

    - Counseling screening for HIV in sexually active women
    - breast pumps (supplies, rental and purchase ;
    - counseling during pregnancy to help promote breastfeeding;
    - counseling for sexually transmitted infections and domestic violence
    - womens contraceptives, sterilization procedures and counseling.

You may call Customer Service using the number on your ID card for additional information about these services.

We provide benefits for:

Well-baby/child care:

- Prenatal care;
- Initial hospital care;
- Well-child care including standard routine pediatric immunizations

Please see your Summary of Benefits for Well baby/child care exam schedule.

Well-adult care:

- Screening mammograms for women (Benefits are limited to two radiographic views per breast);
- Screening for cervical cancer and 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 physician, certified nurse practitioner or certified nurse midwife;
- Prostate specific antigen testing and digital rectal examinations;
- Colorectal cancer screening.
- Smoking Cessation

Note: Screenings and other services are generally covered as Preventive Care for adults and children with no current signs or symptoms of a medical condition. Members who have current symptoms of a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit and subject to the coinsurance and /or deductible applicable to your plan.

**Radiation Therapy** We provide Benefits for radiation therapy.

**Reconstructive Surgeries, Procedures and Services** Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

- necessary due to accidental injury; or
- necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
- Medically Necessary Health Care to restore or improve a bodily function, or

- necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
- for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

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

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

- Mastectomy for Gynecomastia
- Mandibular/Maxillary orthognathic surgery
- Port Wine Stain surgery

**Skilled Nursing Facility Services** We provide Benefits for inpatient skilled nursing facility services. Please see your Summary of Benefits for Cost-Shares and limits. We do not cover custodial confinement.

**Speech, Physical and Occupational Therapy** We provide Benefits for short-term speech, physical and occupational therapy on an outpatient basis for conditions that are subject to significant improvement. Please see your Summary of Benefits for Cost-Shares and Limits.. Services are covered only when provided by a licensed professional acting within the scope of his/her license.

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.

No Benefits are provided for speech therapy 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

**Surgical Services** Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.

For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Customer Service.

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

# 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.

**Acupuncture** We do not provider Benefits for acupuncture.

**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, , , holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

**Artificial Hearts** 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.

**Biofeedback** We do not provide Benefits for biofeedback.

**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), except as required by law, and any device to which the FDA has limited access or otherwise limited approval are considered experimental/investigational.

**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 services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

**Genetic Testing and Counseling** We do not provide Benefits for genetic testing (unless otherwise stated in this Contract) 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.

**Health club memberships**, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion applies to health spas.

**Hearing Care** We do not provide Benefits for hearing examinations except when related to injury or disease. Please see Hearing Care in the Covered Services section for benefits for hearing aids.

**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.

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

**Maternity Care** We do not provide benefits for Maternity Care. We do provide benefits for complications of pregnancy.

**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;
- Services by an independently billing professional for treating substance abuse.

**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 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.

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

**Orthognathic Surgery** We do not provide Benefits for Orthognathic Surgery, except as stated in the Covered Services Reconstructive Surgeries, Procedures and Services section.

**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.

**Pre-existing Conditions Limitation for Members age 19 and older** We may not provide Benefits for any treatments, services, supplies, prescription drugs, medical equipment or prostheses provided to you for a pre-existing condition for up to 12 months from your enrollment date. In certain circumstances this pre-existing condition restriction may be partially or wholly waived. Please see the "Continuity of Coverage" provision in the "Eligibility, Termination, and Continuation of Coverage" section for more information.

**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.

**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 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.

**Private Duty Nursing** We do not provide Benefits for Private Duty Nursing.

**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 Circumcisions** We do not provide Benefits for routine circumcisions.

**Routine Foot Care** We do not provide Benefits for any services rendered as part of routine foot care.

**Services After Your Contract Ends** We do not provide Benefits for services that are provided after your Contract ends unless you are an inpatient at the time. All Benefits will stop when you are discharged as an inpatient or when you reach any of this Contract's maximum, whichever comes 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. We do not provide Benefits for any services you receive, including, a hospital stay that started prior to the effective date of coverage or while Benefits were available under a previous Contract.

**Services by Ineligible Providers** We do not provide Benefits for services provided by any Provider not listed as an eligible Provider 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, 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.

**Shoe Inserts** We do not provide Benefits for shoe inserts.

**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.

**Sterilizations for Men and Reversals of Sterilizations** We do not provide Benefits for sterilizations for men or services to reverse voluntarily induced sterility for men and women.

**Surrogacy,** services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

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

This exclusion does not apply to services listed as covered in the "Dental Services" provision.

**Travel Expenses** We do not provide Benefits for any travel expenses, whether or not the travel is recommended by a Provider.

**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.

**Weight loss programs.** Weight loss programs , whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, jenny Craig, LA Weight Loss) fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.

**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. However, We, or anyone acting on our behalf will determine the administration of your Benefits. . You may utilize all applicable Complaint and Appeal procedures, as outlined later in this section if you do not agree with our determination.

You may have some responsibility for the cost of health services under your Contract. Your responsibility may take the form of a Coinsurance percentage or a Deductible amount. Please see the "Covered Services" section for the Coinsurance and Deductible 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 and Deductible amount directly to the professional or hospital or other provider of care.

All Benefits for Covered Services will be based on any discounted charge for hospital service or our Maximum Allowable Amount for professional services.

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 Allowable Amount for professionals.

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 Deductibles and Coinsurance, you are not required to pay any balances to the Provider for Covered Services until after we determine the Benefits we will pay.

**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 Allowable Amount, in addition to any applicable Deductible and Coinsurance. We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and our Maximum Allowable Amount.

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 and Member will not be responsible for the difference between the Maximum Allowed Amount and the Non-Network Providers charge. 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

Deductible is the dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before We start to pay for Covered Services subject to the Deductible in each Calendar Year. There are separate medical Deductibles for Network and Non-Network.

However, no one person can contribute more than the individual Deductible to the Aggregate Deductible. Copayments and prescription drugs DO NOT accumulate toward the Deductible or Out-of-Pocket Maximum.

Deductible and coinsurance, if applicable, will apply to a newborn if the mother is discharged and the newborn remains in the hospital.

## 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. Please see your Summary of Benefits for Cost-Shares and Limits.

Your Contract has a Coinsurance requirement, it applies after you have satisfied your Deductible. The annual dollar limit is called the Coinsurance limit. There is a Coinsurance limit on your medical Benefit but not on your prescription drug Benefit.

Coinsurance is a fixed percentage of the Maximum Allowed Amount for Covered Services which the Member is required to pay as specified in the Summary of Benefits.

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 Allowed Amount in addition to any applicable 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 Allowable Amount unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.

## Out-of-Pocket Limits

Out-of Pocket is specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Summary of Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. There are separate Out-of-Pocket Maximums for Network and Non-Network. Refer to the Summary of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached for a Member and/or family, then no additional Deductibles and Coinsurance are required for that person and/or family unless otherwise specified in this Certificate and/or the Summary of Benefits.. No one person can contribute more than the individual Out-of-Pocket limit to the aggregate Out-of-Pocket Limit.

**Changing Your Deductible**

Changing your Deductible may change the amount of Premium You pay Us.

You may decrease your deductible upon renewal.
You can increase your Deductible at any time effective upon renewal or the first of the month following a qualifying event.

Qualifying events are:

- marriage, divorce or legal separation;
- adding or deleting a Dependent;
- birth or adoption of a child;
- end of the Calendar Year a covered Dependent child reaches the maximum age;
- beginning active duty with the Armed Services;
- reaching age 65 or becoming eligible for Medicare;
- death of a Covered Person;
- a court order.

**If you change your plan to another deductible plan, claims payments accumulated to the prior deductible met will not be carried over to the new plan.**

## Contract Changes

We may change this Contract at any time provided the changes have been approved by the Maine Bureau of Insurance, are in accordance with all applicable laws, and we send written notice thirty days in advance to the subscriber's latest address in our records. After we notify the Subscriber of a change, payment of billed charges indicates the acceptance of the change.

## 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'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 will file your claims with us. However, you may need to submit a claim for reimbursement for services from Non-Network Providers.

To receive claim forms, or please call our Customer Service Department at the number on the back of your identification card. 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 365 days after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Member Appeal process, which will consider whether the claim was filed as soon as reasonably possible.

**Releasing Necessary Information** Providers 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 are not required to allow non-compliance with 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. Benefits will never be more than the actual charge. You will receive maximum Benefits when you receive services from Network Providers. 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

**Maximum Allowed Amount**
This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on your Contract's Maximum Allowed Amount for the Covered Service that you receive. Please see the BlueCard Program section for additional information. The Maximum Allowed Amount for your Contract is the maximum amount of reimbursement Anthem will allow for services and supplies:

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

For questions about Covered Services, prior authorization, Maximum Allowed Amount or claims, please call a Customer Service Representative at 1-877-890-4507.

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

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary Health Care. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

**Provider Network Status**

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for your Contract is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in

full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

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

The Maximum Allowed Amount for your Contract will be one of the following as determined by Anthem:

1. An amount based on our non-network provider fee schedule/rate (as required by law), which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Non-Network Provider.

**Providers who are not contracted for this product, but contracted for other products with us are also considered Non-Network. For your Contract, the Maximum Allowed Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.**

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

Customer Service is also available to assist you in determining your Contract's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility.

Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

**For Prescription Drugs:** The Maximum Allowed Amount for prescription drugs is the amount determined by Anthem using prescription drug cost information provided by the pharmacy benefits manager (PBM).

**Member Cost Share**

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

Your cost share amount and Out-of-Pocket Maximum may vary depending on whether you received services from a Network or Non-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Summary of Benefits for your cost share responsibilities and limitations, or call Customer Service at 1-877-890-4507 to learn how this Contract's benefits or cost share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-covered services. You will be responsible for the total amount billed by your Provider for non covered services, regardless of whether such services are performed by a Network or Non-Network Provider. Non-Covered services include services specifically excluded by the terms of your Contract and those services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your lifetime maximum, benefit caps or day/visit limits.

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

**Authorized Services**

In some non-Emergency circumstances, such as where there is no Network Provider available for the Covered Service, we may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. If we authorize a Network cost share amount to apply to a Covered Service received from a Non-Network Provider, you may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. Please contact Customer Service for Authorized Services information or to request authorization.

Example:
You require the services of a specialty Provider; but there is no Network Provider for that specialty in your service area. You contact us in advance of receiving any Covered Services, and we authorize you to go to an

available Non-Network Provider for that Covered Service and we agree that the Network cost share will apply.

Your Contract has a 40% Coinsurance for Non-Network Providers and a 30% Coinsurance for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because we have authorized the Network cost share amount to apply in this situation, you will be responsible for the In-Network Coinsurance of 30% and Anthem will be responsible for the remaining balance.

## The BlueCard Program

**Out-of-area services**
Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When you obtain covered services outside of Anthem's service area, the claims may be processed through one of these Inter-Plan Programs. These programs include the BlueCard Program, described below. They may also include negotiated national account arrangements between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when you access medical care outside Anthem's service area, you will obtain it from Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, you may obtain care from non--participating Providers. Anthem's payment practices in both cases are generally described below.

**BlueCard® Program**

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

When you obtain covered services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed Covered Charges for the covered services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

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

Estimated and average pricing arrangements also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of changes of the past pricing for the types of transactions noted above. But, such adjustments will not affect the price on the claim that Anthem will use to determine the amount you pay.

Also, laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If any state law mandates other liability calculation methods, including a surcharge, Anthem calculates a Member's liability for any covered service according to applicable law.

Under certain circumstances, if We pay the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, We may collect such amounts directly from you. You agree that We have the right to collect such amounts from you.

## 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.

## Pharmacy Benefit Manager (PBM)

The pharmacy Benefits available to you under this Plan are managed by our contracted, Pharmacy Benefit Manager (PBM). PBM is a company with which we contract to manage your pharmacy Benefits. PBM has a nationwide network of retail pharmacies, a mail service pharmacy, and clinical services that include formulary management.

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

You may review a copy of the current formulary on our website at: www.anthem.com. You may also request a copy of the formulary by calling a customer service representative at the number of the back of your ID card. 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. Refer to the Prescription Drug Benefit sections in this Certificate for information on coverage, limitations and exclusions.

**Payment for Prescription Drug Claims** To obtain Benefits for prescription drugs, present your identification card to any pharmacy that has an agreement with PBM, in this or any other state. You must pay any cost-shares plus any deductible amount. 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 PBM, or if you do not use your identification card, you must pay the pharmacy the entire cost for the prescription and submit a claim form to PBM 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.

**For Prescription Drugs:** The Maximum Allowed Amount for prescription drugs is the amount determined by Anthem using prescription drug cost information provided by the pharmacy benefits manager (PBM).

**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. Please call the telephone number on the mail order pharmacy form to speak with a representative regarding the amount to include with your order.

Your financial responsibility (Coinsurance, Deductibles, out-of-pocket limit, etc.) 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.

## 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 Allowable Amount 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.

Special Information If You Become Eligible For Medicare You must notify us if you become eligible for premium free Medicare Part A. Failure to notify us could result in retroactive benefit adjustments if Medicare would have been or is the primary payor. You may choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B coverage. However, your Contract will not provide benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you

become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited enrollment periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

### Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When 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. 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. Anthem will make a good faith effort to obtain all necessary information expeditiously and is responsible for expeditious retrieval of necessary information. The Provider rendering the service may request by telephone, fax or in writing on behalf of the member a reconsideration on an adverse determination within one working day of the receipt of the request. The review shall be conducted by the reviewer who made the adverse determination or a clinical peer designated if the original reviewer cannot be available within one working day.

For initial Utilization Review determinations, Anthem's designated representative shall make the determination and so notify the covered person and their provider within 2 working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.

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. Enrollees may initiate a first level appeal at any time.

**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.

Concurrent review determinations. Anthem or Anthem's designated representative shall make the determination within one working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, Anthem or Anthem's designated representative shall so notify the Member and the provider rendering the service within one working day. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, Anthem or Anthem's designated representative shall notify the Member and the provider rendering the service within one working day. The service shall be continued without liability to the Member until the Member has been notified of the determination.

Expedited Appeals. Anthem or Anthem's designated representative shall establish written procedures for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously jeopardize the life or health of a Member or would jeopardize the Member's ability to regain maximum function. An expedited appeal shall be available to, and may be initiated by, the Member or the provider acting on behalf of the Member.

Expedited appeals shall be evaluated by an appropriate clinical peer or peers. The clinical peer/s shall not have been involved in the initial adverse determination.

Anthem or Anthem's designated representative shall provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all necessary information, including Anthem or Anthem's designated representative's decision, shall be transmitted between Anthem or Anthem's designated representative and the Member or the provider acting on behalf of the covered person by telephone, facsimile, electronic means or the most expeditious method available.

In an expedited review, Anthem or Anthem's designated representative shall make a decision and notify the Member and the provider acting on behalf of the Member via telephone as expeditiously as the Member's medical condition requires, but in no event more than 72 hours after the review is initiated. If the expedited review is a concurrent review determination of emergency services or of an initially authorized admission or course of treatment, the service shall be continued without liability to the Member until the Member has been notified of the determination.

If the initial notification was not in writing, Anthem or Anthem's designated representative shall provide written confirmation of its decision concerning an expedited review within 2 working days of providing notification of that decision.

## 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. 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.

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. A decision will be issued within twenty (20) working days of receipt of the request for an Appeal.

The decision shall contain:

- The names, titles and qualifying credentials of the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;
- The reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the Member. Where a Member had previously submitted a written request for the clinical review criteria relied upon by Anthem or Anthem's designated representative in rendering its initial adverse determination, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision.
- The notice must advise of any subsequent appeal rights, and the procedure and time limitation for exercising those rights. Notice of external review rights must be provided to the enrollee and a description of the process for submitting a written request for second level grievance review.

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

**If you choose to pursue a voluntary second level Appeal, you will have the opportunity to appear before the review panel in person, or at Anthem's expense via conference call, video conferencing or other appropriate technology to present your concerns regarding our adverse benefit determination.**

**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. If you do not request the opportunity to appear in person, the decision for second level grievance reviews will be issued within 30 calendar days. If you do request the opportunity to appear in person, the review will be conducted within forty-five (45) working days of receipt of the 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.

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

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

A Member has the right to:

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

## External Review Process

Your authorized representative is 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.

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, may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, preexisting 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 has failed to make a decision on an Appeal within the time period required;
- Anthem 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. 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

No legal action may be brought against Anthem 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 written external review decision; or
- The date of issuance of the underlying adverse Level One Appeal decision or the Level One grievance determination notice.

# Section Six - Definitions

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

**Accident Care** Treatment of an accidental bodily injury sustained by the Member that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

**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 Out-of-Pocket Limit** The limit on the Deductible and Coinsurance you pay each year. After you meet the annual out-of-pocket limit, you pay no further Deductible or Coinsurance for most services.

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

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

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

**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 paid toward the cost of some Covered Services.

**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 and your application (including Health History Statement).

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

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

**Covered 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 Health Care or otherwise specifically included as a benefit under this Certificate.
b. Within the scope of the license of the Provider 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 Certificate.

**Creditable Coverage** (Prior Coverage) Coverage under an individual or group contract or policy that was in effect within 3 months before you were eligible for coverage under this Contract if you apply when initially eligible, or within 3 months of your effective date if you apply as a Late Enrollee. Creditable coverage includes Group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, qualified public health plan, the Peace Corps health benefit plan, S-CHIP, or a qualified foreign health plan. In calculating the period of Creditable Coverage, all periods of coverage under all types of Creditable Coverage are added together unless there is a consecutive 90-day or longer break in the time period the individual has Creditable 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;
- 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 Allowable Amount 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 laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

**Dependent** The eligible Subscribers lawful spouse, children and others as outline in the "Eligibility, Termination and Continuation of Coverage" section of this Certificate.

**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 Partner** The definition of Domestic Partnership for this rider shall be two individuals, of the same sex or opposite sex, that have been each others sole domestic partner for 12 months or more; are mentally competent; at least 18 years old; who are not related in any way (including by blood or adoption) that would prohibit marriage under state law; not married to or separated from anyone else; and are financially interdependent.

**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.

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

**Effective Date**The first day of coverage with Anthem Blue Cross and Blue Shield

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**Emergency Service (Emergency Room Care)** means, with respect to an emergency medical condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

2. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

**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 determines to be experimental or investigational.

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

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

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

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

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

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

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

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

(i) Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;

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

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

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

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

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

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

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

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

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

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

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

(vii) Medical records; or

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

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

**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.

**Federally Eligible Individual** To qualify as a Federally Eligible Individual, you must meet **all** of the following criteria:

- You must have had 18 months of continuous creditable coverage through one or more health plans, with no break in coverage exceeding 63 days. (Please see the definition of "Creditable Coverage" in this section.)
- Your most recent prior creditable coverage must have been in effect within 63 days of applying for this insurance coverage.
- Your most recent prior creditable coverage must have been a group, government or church health plan.
- You must not qualify for any group health plan or government program, such as Medicare or Medicaid.
- Your most recent prior creditable coverage must not have been terminated because of nonpayment of premiums, fraud or intentional misrepresentation of a material fact.
- If offered COBRA, you must have elected and exhausted COBRA Benefits.

**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.

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

**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.

**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 Allowed Amount (MAA)** The maximum amount that we will allow for Covered Services you receive. For more information, see the "Benefit Determinations, Payments and Appeals" section.

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

**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** Health care Providers that have a written agreement with Anthem to furnish health care services under this Contract. Also referred to as participating Providers.

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

**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.

**Pharmacy and Therapeutics Committee** Our committee made up of Maine-based physicians and other experts in medicine and pharmacy.

**Physician** See definition of "Provider."

**Pre-existing Condition for Members age 19 and older** The existence of symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment; or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services during the 12 months immediately preceding the effective date of coverage.

**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"; any other drug we may approve through our drug approval process.

**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, agency, or an independently billing, licensed health care specialist acting within the scope of his or her license. 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 Facilities
- Licensed pharmacies
- Acute care psychiatric and rehabilitation Hospitals
- Independent laboratories
- Freestanding Imaging Centers
- Family planning agencies
- Durable Medical Equipment Providers
- Home infusion Providers
- Other Providers that have written participating agreements with us;
- Other Providers, as required by law.

Physicians
- Doctor of Medicine
- Doctor of Osteopathy

Other Professionals
- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Independent Practice Dental Hygienist
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Pastoral Counselor
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Other Professionals that have written participating agreements with us;
- Other Professionals 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.

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

**Subcontractor** An organization or entity that provides particular services in specialized areas of expertise. Examples of subcontractors include, but are 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.

**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.

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

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

**Treatment of Autism Spectrum Disorders** The following types of care prescribed, provided or ordered for an individual diagnosed with autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;
(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and
(3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

**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.

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# Maternity and Prescription Drug Out-of-Pocket Limit Amendment to Certificate of Coverage

Your Anthem Blue Cross and Blue Shield HealthChoice Plus (10971ME), Certificate of Coverage is changed as stated in this amendment.

**The Covered Services section is changed as follows:**

**The Hospital Services section is changed with addition of the following bullet:**

- **Delivery of a newborn (please see "Maternity Care" section below for more information);**

**The following "Maternity Care" section has been added:**

**Maternity Care** We provide Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. Routine newborn care does not include any services provided after the mother has been discharged from the hospital. All other plan provisions such as Deductible and Coinsurance, if applicable, will apply to the newborn if the mother is discharged and the newborn remains in the hospital. Please see your Summary of Benefits for Cost-Shares and Limits.

**The Exclusions Section is changed with the deletion of the "Maternity Care" exclusion.**

**The Benefit Determinations, Payments and Appeals section, Claims Payment subsection is changed by deleting the 'How Your Deductible Works", "Coinsurance" and "Out-of-Pocket Limits" provisions and replacing it with the following:**

**How Your Deductible Works**
Deductible is the dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before We start to pay for Covered Services subject to the Deductible in each Calendar Year. There are separate medical Deductibles for Network and Non-Network.

However, no one person can contribute more than the individual Deductible to the Aggregate Deductible. Copayments DO NOT accumulate toward the Deductible or Out-of-Pocket Limit.

Deductible and Coinsurance, if applicable, will apply to a newborn if the mother is discharged and the newborn remains in the hospital.

Also, laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If any state law mandates other liability calculation methods, including a surcharge, Anthem calculates a member's liability for any covered service according to applicable law.

**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. Please see your Summary of Benefits for Cost-Shares and Limits.

Your Contract has a Coinsurance requirement, it applies after you have satisfied your Deductible.

Coinsurance is a fixed percentage of the Maximum Allowed Amount for Covered Services which the Member is required to pay as specified in the Summary of Benefits.

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 Allowed Amount in addition to any applicable 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 Allowable Amount unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. No authorization is required if it has been determined by Anthem that there is no participating provider reasonably available in network. Please refer to section 5 "Authorized Services" in this Certificate for further information.

**Out-of-Pocket Limits**
Out-of Pocket is specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Summary of Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. There are separate Out-of-Pocket Limits for Network and Non-Network. Refer to the Summary of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached for a Member and/or family, then no additional Deductibles and Coinsurance are required for that person and/or family unless otherwise specified in this Certificate and/or the Summary of Benefits. No one person can contribute more than the individual Out-of-Pocket Limit to the aggregate Out-of-Pocket Limit.

There is a separate Out-of-Pocket Limit (Network and Non-Network combined) on your prescription drug Benefit. Please refer to your Summary of Benefits for Cost-Shares and Limits.

**Your Summary of Benefits "Prescription Drug" provision is changed with the addition of a $3,500 Individual and $7,000 Family separate Total Out-of Pocket Limit (Network and Non Network Combined).**

**Your Summary of Benefits "Maternity Care" provision is updated to show that Maternity is now covered under your HealthChoice Plus plan.**

All other terms, conditions, limitations and exclusions of your Anthem Blue Cross and Blue Shield Certificate of Coverage apply to this amendment.

Kathleen S. Kiefer
Corporate Secretary

Anthem BlueCross BlueShield

# Acknowledgement of Understanding
# and
# Grievance and Appeal
# Amendment to
# Certificate of Coverage

Your Anthem Blue Cross and Blue Shield HealthChoice Plus ((10971ME), HealthChoice HDHP (029247), HealthChoice (028645), HealthChoice A (028645A), HealthChoice B (028945B), HealthChoice Standard (048066), HealthChoice Basic (048065), Lumenos® Individual HIA Plan (7116ME), Lumenos® Individual HIA Plus Plan (7117ME), or Lumenos® Individual HSA Plan (7118ME) Certificate of Coverage is changed as stated in this amendment.

**The "Benefit Determinations, Payments and Appeals"' section is changed by adding the following provision:**

## Acknowledgement of Understanding

The Subscriber hereby expressly acknowledges its understanding that this policy constitutes a contract solely between Subscriber and Anthem Health Plans of Maine, Inc, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use the Blue Cross and/or Blue Shield Service Mark in the State of Maine, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Subscriber for any of Anthem's obligations to the Subscriber created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

**Your "Complaints and Appeals" Section is deleted and replaced with the following:**

## Complaints and Appeals

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

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

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

**Complaints Requiring Immediate Intervention**

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

Concurrent review decisions. Anthem will make the decision within one working day after getting all needed information.

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

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

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

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

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

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

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

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

## Appeals

**Level One Appeal Process**

You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing

and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. More information may be submitted by or for the Member, any treating physician, or Anthem. A finding will be made within thirty (30) days after we receive the request for an Appeal.

The decision will include:

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

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

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

**On a Level Two Appeal**, the entire record will be reviewed.

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

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

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

A Member has the right to:

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

**External Review Process**

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

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

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

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

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

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

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same Adverse Health Care Treatment Decision for which you have already received an external review decision.

**The "Definitions" section is changed by adding the following definition:**

**Adverse Determination**" or "**Adverse Health Care Treatment Decision**" means a health care treatment decision made by or on behalf of a carrier offering a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Health care treatment decision" means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

All other terms, conditions, limitations and exclusions of your Anthem Blue Cross and Blue Shield Certificate of Coverage apply to this amendment.

Kathleen S. Kiefer
Corporate Secretary
Anthem Blue Cross and Blue Shield

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