Maine Coverage Details

Things you need to know before you buy...

Anthem BlueCross BlueShield

HealthChoice® Plus

Before choosing a health care plan, please review the following information along with the other materials enclosed.

Who can apply?

To be eligible for membership as a policyholder, the applicant must:

1. Be a resident of Maine;
2. Not have any other type of health insurance. If the applicant has other insurance coverage in-force, he or she must replace that coverage;
3. Agree to pay for the cost of premium that Anthem Blue Cross and Blue Shield (Anthem) requires; and
4. Satisfy the following requirements to guarantee renewability:
   a) Eligibility criteria continues to be met;
   b) There are no acts, practices or omissions that constitute fraud or intentional misrepresentation of material fact found on the application;
   c) Membership has not been terminated by Anthem under the terms of this policy.

If an individual is under 26 years of age and is covered either by his or her parents or guardians as defined by the State of Maine, he or she is eligible for coverage provided he or she meets eligibility criteria specified in the Eligibility policy stated above. Anthem requires the parent/guardian to sign the applications as the applicant for the insured. Married couples and domestic partners that meet eligibility requirements may also apply. Families with dependent children under age 26 are eligible as well.

Pre-Existing conditions

For applicants age 19 and older, Anthem Blue Cross and Blue Shield will not provide benefits for 12 months from the date of application for a pre-existing condition. A pre-existing condition is any 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. The 12 month period is decreased if the Member had prior creditable coverage within the last 90 days.

Utilization management and case management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific time frames to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prior authorization/Pre-admission review

Prior Authorization (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary; and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for Prior Authorization may include, but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prior Authorization is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care, and assigns an expected length of stay if needed.

Concurrent review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities and home health care services). The review includes physicians and member-assigned health care professionals (or member authorized representative), and takes place by telephone, electronically and/or on-site.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case management

Case managers are licensed health care professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What our Individual health plans do not cover

The following limitations and exclusions will help you understand what your health care plan does not include. These are just some of the plans' limitations and exclusions. In addition to the other limitations, conditions and exclusions set forth elsewhere, no benefits will be provided for expenses related to the services, supplies, conditions or situations described in this section. These items and services are not covered even if you receive them from your Provider or according to your Provider's Referral. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is the final authority for determining if services or supplies are covered and/or Medically Necessary.

Exclusions

- Acupuncture
- Alternative medicines or complementary medicines
- Artificial hearts
- Benefits available from other sources when there is no charge to you (does not apply to Medicaid)
- Biofeedback
- Blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available
- Cosmetic services
- Custodial care
- Dental services
- Experimental/investigational services
- Genetic testing and counseling
- Health club memberships or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician
- Hearing care
- Infertility related services and drugs
- Leased services and facilities
- Maintenance therapy
- Major disaster, epidemic, or war
- Massage therapy
- Medically unnecessary services
- Medicare eligible charges under federal Medicare Secondary Payor regulations
- Miscellaneous expenses
- Missed appointments
- Non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices
- Nutritional and/ or dietary supplements
- Orthognathic surgery
- Orthotic devices
- Personal comfort items
- Pre-existing conditions for members age 19 and older for up to 12 months from your enrollment date
- Prostheses designed exclusively for athletic purposes
- Private duty nursing
- Refractive eye surgery
- Reversal of voluntarily induced sterility
- Routine circumcisions
- Routine foot care
- Services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government
- Services before the effective date or after your contract ends
- Services by ineligible providers or professionals
- Services by relatives or volunteers
- Services provided by the federal government or any state, county or municipal government.
- Services related to non-covered services
- Sex changes
- Shoe inserts
- Speech therapy for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting
- Surrogate pregnancy related services
- Travel expenses
- Reversals of sterilizations
- Temporomandibular Joint (TMJ) Syndrome services
- Treatments, services, or supplies provided to veterans by the Department of Veterans Affairs
- Treatments, services or supplies provided by or through any health care facility of the uniformed services
- Vision care
- Weight loss programs

Limitations

These policies cover certain services up to a preset limit. Your contract will have detailed information on the benefit limitations that are outlined below.

- *Cardiac Rehabilitation* — Limited to 24 visits per condition in and out of network combined.
- *Early Intervention* — Limited to $3,200 per calendar year and $9,600 per lifetime. This benefit is only available for children up to their 3rd birthday (birth to 2).
- *Hearing Aids* — One hearing aid per Member for each hearing-impaired ear every 36 months, up to 18 years of age.
- *Home Health* — Limited to 90 visits per calendar year in and
- out of network combined.
- *Manual Medical Interventions* — Manipulative therapy is limited to 15 manipulations per calendar year in and out of network combined.
- *Mental Health/Substance Abuse* — Limited to 20 inpatient days and 25 outpatient visits per calendar year in and out of network combined.
- *Outpatient Physical, Occupational and Speech Therapy* — Limited to 20 visits per calendar year combined for all therapies whether performed in or out of network.
- *Preadmission Penalty* — Failure to gain prior authorization before a nonemergency hospital admission may result in a $500 penalty per admission. This penalty doesn't count toward deductible or coinsurance limits.
- *Skilled Nursing Facilities* — Limited to 100 days per calendar year in and out of network combined.

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Have privacy for your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- For assistance at any time, contact your local insurance department:

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

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits, or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Notices of privacy practices

We've combined a couple of required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

State notice of privacy practices

As mentioned in our HIPAA notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully. We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your protected health information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or, to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is the genetic information of an individual for such purposes.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who should not have access out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy
- Surgery and reconstruction of the other breast to restore a symmetrical appearance
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema

All applicable benefit provisions will apply, including existing deductibles, copays and/or coinsurance.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem producer to request them.

The content of this document is not a legal policy or contract. It is intended as a quick reference to inform you about the health plans, programs and services available to individuals from Anthem in Maine. Please refer to your contract documents to determine your rights to benefits and coverage, as well as your obligations under the health plan you purchase.

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