

STATE OF MAINE HEALTH PLAN

MEDICAL COVERAGE

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Member Services number on the back of your id card or in your Certificate of Coverage.

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

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS:

There are hospitals, health care facilities, physicians or other health care providers that are not included in this Plan's Network. Your financial responsibilities for payment of covered services, including "cost shares," such as coinsurance, copayments, and out of pocket maximums may be higher if you use a Non-Network Provider. Additionally, you may have some cost-sharing for preventive benefits if you do not use a Network Provider. Please refer to the online provider directory available at Anthem.com to determine if a particular Provider is in the Network, or contact Member Services for assistance.

Network Directory

Information about Network Providers is available in the online network directory at www.anthem.com. You can find information such as the Provider's location and qualifications. If you don't have access to the website or need help to find a doctor who is right for you, call the Member Services number on your ID card. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with Member needs.

Introduction

This Benefit Booklet describes the benefits available to Plan Participants under the State of Maine Health Plan (referred to as the Plan).

The benefits described in this Benefit Booklet are those in effect as of July 1, 2017.

Every attempt has been made to be informative about benefits available under the Plan and those areas where a benefit may be lost or denied.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the employer, Plan Administrator (Anthem Blue Cross Blue Shield), Contract Administrator, and other individuals as may be party to or associated with the Plan shall be guided solely by this Benefit Booklet.

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

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

Paying Subscription Charges/Administrative Fees and Renewal

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

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

The State of Maine hopes and expects to be able to continue the State of Maine Health Plan indefinitely but reserves the right to make changes in the Plan or to discontinue the Plan at any time. Should the Plan be terminated, Plan Participants will be notified at least ten (10) days in advance of the termination date. Any and all amendments to the Plan shall be in writing and shall be authorized by the signature of the Executive Director of the State of Maine's Division of Employee Health and Benefits.

Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose a Network primary care physician, also called a PCP, if your health plan requires it.
- Treat all doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.
- Give the Claims Administrator, your doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This

may include information about other health insurance benefits you have along with your coverage with us.

- Inform the Claims Administrator's Member Services Department if you have any changes to your name, address or family members covered under your Plan.

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

The Claims Administrator wants to provide high quality benefits and customer service to its Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

The Claims Administrator is committed to communicating with its Members about their health plan, regardless of their language. The Claims Administrator employs a Language Line interpretation service for use by all of its Member Services Call Centers. Simply call the Member Services phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will contact the Claims Administrator to help with Member needs.

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Claims Information

For questions about Covered Services or claims, please call a Member Services 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.

Benefit Summary

The Benefit Summary gives you information on benefit levels, Deductibles, Copayments, Coinsurance and maximums that apply to your Plan.

Section One: General Information

The State of Maine Health Plan is a self-funded health plan. Medical claims administration will be performed by the Contract Administrator, Anthem Blue Cross and Blue Shield.

Your Employer will notify all Plan Participants of Material Modifications or Reductions in covered services or benefits as follows:

- a) Material modifications to the Plan will be communicated to Plan Participants no later than 210 days after the end of the Plan Year in which the modification is adopted.
- b) Material reductions to the Plan will be communicated to Plan Participants no later than 60 days after the adoption of the modification.

Participating Employer

State of Maine

The Plan Effective Date

July 1, 2017

Eligible Classes of Members

Employees: as defined by the State of Maine Statute, Title 5, Section 285, paragraph 1A-K may enroll in this plan.

Retirees: retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or were covered under this plan or another plan sponsored by your employer on the day before you retired; and retire under your employer's IRS-qualified retirement plan.

For more information on eligibility for this Plan, please contact the Employer.

The Health Plan does not base eligibility on any of the following health status-related factors: medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Date of Eligibility

Occurs upon completion of the Waiting Period

Plan Name

The name of the Plan is the State of Maine Health Plan

Name and Address of Plan Sponsor

State of Maine
Division of Employee Health & Benefits
114 State House Station
Augusta, ME 04333-0114

Employer Identification Number (E.I.N.) Assigned To Sponsor by the IRS

01-6000001

Type of Coverage Provided Under The Plan

Group Medical Benefits

Type of Administration

Contract Administration by:

Anthem Blue Cross and Blue Shield

2 Gannett Drive

South Portland, ME 04106

Anthem Blue Cross and Blue Shield provides administrative medical claims payment services only and does not assume any financial risk or obligation with respect to claims.

Name, Business Address and Telephone Number of the Plan Administrator

State of Maine

Division of Employee Health & Benefits

114 State House Station

Augusta, ME 04333-0114

(800) 422-4503

Agent for Legal Service

The Agent for service of legal process is the Plan Administrator and service may be made at the above address. The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility or denial or loss of any benefits are described in this Plan Document.

Decisions Regarding Claims

If you have a claim which has been partially or wholly denied, and you wish to question the claims decision, contact the Plan Administrator (named above), who will provide you with the reasons for the decision and the procedure to follow should you wish a full review of your claims. Please refer to the "Benefit Determinations, Payments and Appeals" section of the Plan for details.

The Sources of Contribution to the Plan

The Employer and primary subscribers will contribute the total cost for the Plan.

Plan Year

The financial records to the Plan are maintained on the basis of Plan Years commencing on July 1.

This booklet is intended to be a complete description of your Medical Benefits. It would be advisable to take this booklet with you to your physician to avoid questions about benefits available under The Plan.

Reservation of Rights: As sponsor of the Plan, the State of Maine reserves the right to amend or modify the eligibility requirements or the level of benefits, and to make any other changes, including termination of the Plan, in its health plan policies at any time and for any reason whatsoever.

Section Two: Eligibility, Termination, and Continuation of Coverage

Eligibility

Beginning Coverage

Before your coverage begins we must accept the Group's application, your application, required supporting documentation and payment for your coverage. The Contract Holder acts as your remitting agent and is responsible for sending us all applications and payments for coverage, as well as notifying the Plan Participants of any changes in payroll or pension deductions for coverage, rate changes, changes in this Plan or in any documents that comprise the Plan, or termination of the Plan or your coverage under the Plan.

Who is an Eligible Group Member?

1. The Plan Participant (Employees and Retirees);
2. The Plan Participant's legal spouse,
3. The Plan Participant's domestic partner who meets the rules set by your employer (to be eligible for coverage, the Plan Participant and domestic partner will need to complete and sign a Domestic Partner Affidavit (supporting documentation required))
4. The Plan Participant's/spouse's/domestic partner's children under age 26:
 - a. Newborn children
 - b. Biological children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the Plan Participant or children for which the Plan Participant is a legal guardian;
5. The Plan Participant's/spouse's children aged 26 and older if they are mentally or physically disabled. The disability must have begun before the child's 26th birthday, and the child must have been covered on this Plan prior to reaching age 26. A child cannot be added due to disability if the disability began or was determined at age 26 or later.

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the primary subscriber, and meet all Dependent eligibility criteria established by the Employer.

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

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

If an employee and spouse/domestic partner are both eligible for employee coverage, only one will be eligible for coverage with respect to dependents. In addition, the spouse/domestic partner may be deemed to be a dependent and not an employee with respect to the parts of this Plan which provide both employee and dependent coverage.

We will determine the effective date of coverage for the primary subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call Anthem Member Services at the number on your ID card.

The Contract Administrator reserves 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.

Membership Additions

If you wish to add eligible family members you must:

- Notify the Division of Employee Health & Benefits within 60 days of qualifying life event by filing a completed application with required supporting documentation; and
- Pay the applicable cost for the Plan.

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage. The Division of Employee Health & Benefits can tell you when enrollment for added family members is allowed under this Plan.

You will need to enroll within 60 days of your eligibility date. If you miss this initial enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period or experience a Qualifying event as described below.

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

Birth A newborn is automatically covered for 31 days from the moment of its birth under the Plan Participant's coverage unless the Plan Participant notifies us that the child will not be covered under the Plan. For coverage beyond 31 days the Plan Participant must add newborn within 60 days of date of birth.

- **Within 60 days from the date of birth**, coverage is continuous from the moment of birth. We will collect applicable charges.
- **After 60 days from the date of birth**, coverage may begin on the Group's next annual Enrollment Period.

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

- **Within 60 days from the date the child is adopted or placed for adoption with the Plan Participant 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 60 days from the date the child is adopted or placed for adoption with the Plan Participant and/or spouse**, coverage may begin on the Group's next annual Enrollment Period.

Marriage When the Plan Participant marries, if we receive the spouse's (and children's, if applicable) completed application for change and supporting documentation (e.g. marriage license, birth certificate):

- **Within 60 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 and copy of marriage license.

Court Order Changing Custody When a court order is issued changing custody of a Dependent child, if we receive the application for change and supporting documentation (court order):

- **Within 60 days of the date of the court order**, coverage will begin on the first of the month following receipt of the application and court order unless otherwise stated in the court order.

Dependent Involuntarily Losing Eligibility Under Other Coverage When a dependent with other coverage involuntarily loses that coverage, if we receive the application for change and supporting documentation:

- **Within 60 days of the date the dependent loses coverage**, coverage will begin on the date of application for enrollment.

If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

Annual Enrollment Period After the initial eligibility date, applications may be submitted during the annual enrollment period established by the Plan. The annual enrollment period is the period designated by the Plan when the employee can elect coverage or modify enrollment. Note: Retiree members are not eligible to make changes during this period.

Qualifying Life Events After initial eligibility, applications may also be submitted within 60 days of certain qualifying life events. Ineligibility caused by fraud or misrepresentation does not qualify. Qualifying life events include:

- Marriage or 6-month anniversary of a domestic partner relationship;
- Marriage of covered dependent child (removal of that child only);
- Divorce or legal separation as recognized under applicable state law;
- Death of a spouse/domestic partner or Dependent child;
- End of domestic partner relationship;
- Birth, adoption, or placement for adoption;
- Termination or commencement of spouse's/domestic partner's employment;
- Annual enrollment period of employee's spouse/domestic partner or dependent;
- Change in employment of the employee or spouse/domestic partner, from full-time to part-time status or part-time to full-time status;
- The taking of an unpaid leave of absence by the employee or his/her spouse/domestic partner;
- Termination of the Plan;
- A court order requires that coverage be provided for the primary subscriber's spouse/domestic partner or the minor child of the primary subscriber or the primary subscriber's spouse/domestic partner;
- A court order is issued changing custody of a child. The effective date of coverage is the first of the month following receipt of court order unless otherwise stated in the court order;
- You have exhausted your Consolidated Omnibus Budget Reconciliation Act (COBRA) Benefits;
- A Dependent satisfying or ceasing to satisfy the requirements for Dependents;
- Loss of Medicaid;
- Incarceration for one month or more.

The Contract Holder can tell you when enrollment for added family members is allowed under this Plan.

Special Enrollment If you decline coverage for yourself or your Dependents (including your spouse/domestic partner) because you and your Dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your Dependents, provided you meet each of

the applicable conditions outlined below, and you request enrollment within 60 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 60 days of the marriage, birth, adoption or placement for adoption.

Conditions required for enrollment:

1. The employee has declined enrollment in writing stating that coverage under other health insurance coverage was the reason for declining coverage;
2. When the employee declined enrollment for employee and/or Dependent coverage, the employee and/or Dependent had COBRA continuation coverage under other health insurance and COBRA continuation coverage under that other insurer has since been exhausted; or
3. If the other coverage that applied to the employee and/or Dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
 - a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
 - b. employer contributions towards the other coverage have been terminated; or
 - c. loss of coverage under the Cub Care program.
 - d. the member no longer resides in such coverage's permitted service area provided that no other coverage under the plan is available to the Member;
 - e. benefits are no longer offered to a class of similarly situated individuals. For example, if a Plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the Plan continues to provide coverage to other employees;
 - f. the application of the lifetime maximum benefit through another carrier's coverage;
 - g. a dependent loses eligible dependent status. An employee who is already enrolled in a benefit option may enroll in another option under the Plan if available due to a dependent losing eligible dependent status; or
 - h. a dependent who has other coverage loses eligibility under that coverage; or
4. If the retiree and/or dependent is eligible pursuant to Title 5 MRSA §285.

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

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

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

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

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

Return From Military Service

If the employee returns from full-time active service following a call to active military duty, no waiting period applies. The employee and eligible family Members can reenroll in the Plan, provided the employee applies for reemployment within the timeframe permitted under the Uniformed Services Employment and Reemployment Rights Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 60 days of your reemployment date. Coverage is effective on the effective date of your reemployment.

Termination of Coverage

Termination Date for Employees, Retirees and Dependents

Employee coverage will end on the earliest to occur of the following dates:

- The date on which the Plan is terminated;
- The last day of the period for which contribution has been made, if the employee fails to make any contribution which may be required.

Retiree coverage will end on the earliest to occur of the following dates:

- The date on which the Plan is terminated;
- The last day of the period for which contribution has been made, if the retiree fails to make any contribution which may be required.

Coverage with respect to a dependent will terminate upon the earliest to occur of the following dates:

- The effective date on which the primary subscriber coverage terminates;
- The day the primary subscriber's dependent coverage under the Plan terminates;
- The last day for which contribution has been made, if the employee fails to make any contribution which may be required.
- The end of the month in which the covered dependent does not satisfy the eligibility requirements, as defined herein.

Continuation of Coverage

If your Group health coverage ends, you may be eligible for Group continuation coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA).

Group Continuation Coverage

Federal law requires that some employers sponsoring Group health plans offer employees and their families a temporary extension of health coverage at the rate of your premiums plus an administrative fee, when that coverage would otherwise end because of the occurrence of certain qualifying events. You are responsible for payment of the coverage premium at your Group rate plus the administration fee.

Qualifying events include:

- Death of the employee/retiree;
- Termination of the employee's employment or reduction in hours of employment;
- Divorce or legal separation (if recognized in your state of residency) from the employee/retiree;
- A Dependent child ceasing to be a Dependent;
- A retiree's coverage ceasing because of the employer's bankruptcy; and
- A covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act.

Notification - Under the law the employee or a family member (a qualified beneficiary) has the responsibility to inform the employer within 60 days of a:

- Divorce;

- Legal separation (if recognized in your state of residency); and/or
- Child losing Dependent status under the Group health plan.

In any event, your continued Group coverage under this Contract (COBRA) will end if any of the following events occur:

- Your employer no longer provides our health insurance to any of its employees;
- We do not receive your coverage premium payment. In such case, your COBRA coverage will be retroactively terminated to the first day of the period for which the premiums have not been timely paid;
- You become a covered employee under any other Group health plan after the date you elect COBRA continuation coverage;
- You remarry and become covered under a Group health plan after the date you elect COBRA continuation coverage;
- You become entitled to benefits under Medicare after the date you elect COBRA continuation coverage;
or
- Your COBRA entitlement period ends.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Group rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Coverage Due To Military Service

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

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

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

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

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

Section Three

Utilization Management

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

If you have a health concern, please contact your Physician.

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

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

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

The Contract Administrator (Anthem) may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in the Contract Administrator's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Contract Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Contract Administrator may also exempt your Claim from medical review if certain conditions apply.

Just because the Contract Administrator exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that the Contract Administrator will do so in the future, or will do so in the future for any other Provider, Claim or Member. The Contract Administrator may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory or contacting Member Services at the number on the back of your ID card.

The Contract Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Contract Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Medical Policy and Technology Assessment

The Contract Administrator (Anthem) reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered. However, the Benefit Booklet and the Administrative Services Agreement take precedence over medical policy. Medical technology is constantly changing and we reserve the right to review and update medical policy periodically.

Prior Authorization

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

Most Network Providers know which services require prior authorization and will obtain any required prior authorization when it is necessary. Your Network Providers have been provided detailed information regarding Utilization Management procedures and are responsible for assuring that the requirements of Utilization Management are met. The ordering (or "requesting") Provider, facility or attending physician will contact the Contract Administrator to request a prior authorization review ("requesting Provider"). The Contract Administrator will work directly with the requesting Provider for the prior authorization request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for prior authorization:

- Services provided by a Network Provider: The Provider is responsible for prior authorization
- Services provided by a BlueCard or Non-Network Provider: The Member is responsible for prior authorization.

The member is financially responsible for services and/or settings that are not covered under the Benefit Booklet based on an adverse determination of Medically Necessary Health Care or Experimental or Investigational services.

If you have any questions regarding the information contained in this section, you may call the Member Services telephone number on the back of your Identification Card or visit www.anthem.com.

Procedure for Appeal of Medical Necessity

If you disagree with the determination of medical necessity, you have the right to Appeal as outlined in the "Benefit Determinations, Payments and Appeals" section of this Benefit Booklet.

Inpatient Admission Review

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

You, your Physician or the Provider must call the telephone number on your ID card for review before you are admitted. It is your responsibility to make sure the call has been placed. If you do not receive pre-admission review before you are admitted for non-Emergency Services, Benefits will be reduced by up to \$500 for the admission. This penalty amount does not count toward your Deductible or Coinsurance limit. A penalty will not be applied to you for medically necessary inpatient facility services from a Network or BlueCard provider.

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

Post-Admission Review All Inpatient admissions for emergency and maternity services are subject to post-admission review. For post-admission review of an emergency admission, you, a family member, your physician, or the Provider should call within 48 hours after you are admitted. For maternity post-admission review, you, a family member, your Physician, or the Provider should call if the Hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. The Contract Administrator 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-Network Hospital or other Non-Network health care facility, Benefits are provided at the higher benefit level only until the Contract Administrator determines that your condition reasonably permits your transfer to a Network Hospital or other Network 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 and maternity admissions, call the telephone number on your ID card. You can call 24 hours a day, seven days a week. During non-business hours, you may be asked to leave your information on a confidential voice messaging system.

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

Continued Inpatient Stay Review During your stay in the Hospital, the Contract Administrator’s 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 the Contract Administrator determines that Inpatient Benefits are no longer approved, your attending Physician will be notified immediately by telephone and you will be notified by letter that Benefits will not be available beyond a certain date specified in the letter, if you are liable for the entire cost of continued care.

If you elect to continue your Hospital stay after you have been notified by letter that no further Inpatient days are approved, Benefits for Inpatient days beyond the date specified in the notification letter will be denied. You are entitled to Appeal this determination as outlined in this booklet.

Note:

Maternity Admissions - This Plan generally may not, under federal law, restrict Benefits for a mother or newborn child for any Hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit

the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

The Inpatient length of stay for a maternity admission will be determined by the attending Physician in consultation with the patient as outlined in the "Covered Services" section. In any case, this Plan may not, under federal law, require authorization from the Contract Administrator for prescribing a length of stay that does not exceed 48 hours (or 96 hours as applicable).

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, you may call the telephone number on your ID card.

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

Mental Health/Substance Abuse Review

Prior authorization is required for Inpatient services as well as partial hospitalization and intensive outpatient Mental Health and Substance Abuse services before services are provided. If prior authorization is not obtained, benefits may be denied or a penalty may be applied. Unless you have an Emergency Medical Condition, you or the Provider must call the telephone number on your ID card for prior authorization before you receive the services. Please see the "Inpatient Admission Review" section for any penalty that may apply when prior authorization is not obtained for inpatient services. Please see your Schedule of Benefits for Benefits and cost shares that apply.

Health Plan Individual Case Management

The Contract Administrator's health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. These programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

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

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

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

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service through the Claims Administrator's Case Management program. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator's will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan.

A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

Continuity of Care

If your In-Network Provider leaves our network because we have terminated their contract without cause, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. "Active treatment" includes:

- 1) An ongoing course of treatment for a life-threatening condition,
- 2) An ongoing course of treatment for a serious acute condition,
- 3) The second or third trimester of pregnancy; or
- 4) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care would worsen your condition or interfere with anticipated outcomes.

An "ongoing course of treatment" includes treatments for mental health and substance use disorders.

In these cases, you may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details.

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. The Contract Administrator's 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, the Contract Administrator will authorize Covered Services from a Non-Network Provider. Benefits will be reimbursed at the higher Network level.

How to Access Primary and Specialty Care Services

Your health Plan covers certain primary and specialty care services. To access primary care services, simply visit any Network physician who is a general or family practitioner, internist or pediatrician. Your health Plan covers care provided by any Network specialty care Provider you choose. Referrals are never needed to visit any Network specialty care Provider.

To make an appointment call your physician's office:

- Tell them you are an Anthem PPO member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.

- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

When you need care after normal office hours

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

Program Incentives

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

Section Four

Covered Services

This section, along with the “Exclusions” section, explains health care services for which the Plan will and will not provide Benefits. All Benefits and Covered Services are subject to the Deductibles, Coinsurance, Copayments, maximums, exclusions, limitations, terms, provisions and conditions of this Benefit Booklet, including any attachments and Amendments or riders to this Benefit Booklet. 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 Benefit Booklet, including, use of Network Providers and obtaining any required prior authorization.

The Plan’s payment for Covered Services will be limited by any applicable Copayment, Deductible, or annual or lifetime maximum. Please check your Benefit Summary for Deductibles, Copayments, Coinsurance, maximums, and limitations that apply. Please see the “Utilization Management” section for conditions that apply to all Inpatient admissions.

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

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

A Member’s right to Benefits for Covered Services provided under this Benefit Booklet is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem BCBS Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in the “Utilization Management” section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

Acupuncture The Plan provides Benefits for acupuncture.

Allergy Testing and Injections The Plan provides Benefits for allergy testing and injections.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;

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

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

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

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

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

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

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 The Plan provides 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 The Plan provides Benefits for anesthesia only if administered while a Covered Service is being provided, except as outlined in the 'Dental Procedures' provision. The Plan does not provide Benefits for local or topical anesthesia unless it is part of a regional nerve block.

Autism Spectrum Disorders The Plan provides coverage for members 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 this Benefit Booklet. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

Bariatrics (Morbid Obesity) The Plan provides limited Benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required.

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

Chemotherapy Services The Plan provides 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 the Contract Administrator for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the Contract Administrator for medically accepted indications or as required by law.

Benefits are also available for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.

Clinical Trials

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

Benefits are limited to the following trials:

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

Your Plan may require you to use an In-Network Provider to maximize your benefits.

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

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

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

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

Contraceptives The Plan provides Benefits for medical services, on an Outpatient basis, to prevent pregnancy.

Dental Procedures The Plan will provide Benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable. Examples of vulnerable Members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot

be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result

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

Dental Services The Plan provides Benefits only for the following:

- Setting a jaw fracture
- Removing a tumor (but not a root cyst)
- Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting
- Treatment within twelve months of an accidental injury to repair or replace natural teeth or within twelve months of the effective date of coverage, whichever is later
- Repairing or replacing dental Prostheses caused by an accidental bodily injury within twelve months of the injury or within twelve months of the effective date of coverage, whichever is later.

Services for accidental injuries relating to biting and chewing are not covered.

Diabetic Services The Plan provides Benefits for diabetes medication, equipment, and supplies which are medically appropriate and necessary. Benefits are limited to: insulin, insulin pumps, oral hypoglycemic agents, glucose monitors, test strips, syringes, lancets, and Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by the Contract Administrator.

Diagnostic Services The Plan provides Benefits for Diagnostic Services, including diagnostic laboratory tests and x-rays, when they are ordered by a Provider 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 Benefit Booklet.

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

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

Durable Medical Equipment and Prostheses If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for your disease or injury, Benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. These terms apply to the following services:

Durable Medical Equipment The Plan provides Benefits for the rental or purchase of Durable Medical Equipment. Whether you rent or buy the equipment, the Plan provides Benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, the Contract Administrator will make monthly payments only until the Plan's 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 Plan approval. The Plan does 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.

Prostheses The Plan provides Benefits for Prostheses. Prostheses include artificial limbs and prosthetic appliances. Please refer to the “Exclusions” section for additional information.

Early Intervention Services The Plan provides Benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child’s primary care provider is required.

Emergency Room Care The Plan provides Benefits for emergency room treatment received for medical emergencies once you pay the emergency room cost share listed on your Benefit Summary. You or a designated person should contact your Physician within 48 hours from the time you receive care.

If you are admitted to the Hospital from the emergency room, the emergency room Copayment (if applicable to your Plan) is waived. You or a designated person should contact your Physician within 48 hours from the time you are admitted. If you do not contact your Physician, you or someone you designate should call the telephone number listed on your ID card within 48 hours of admission.

Family Planning The Plan provides Benefits for family planning. See the ‘Contraceptives’ provision within this section for details.

Foot Care The Plan provides Benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Freestanding Imaging Centers The Plan provides Benefits for Diagnostic Services performed by Freestanding Imaging Centers. All services must be ordered by a Provider.

Hearing Care The Plan provides Benefits for wearable hearing aids for covered Members through age 18. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

Home Health Care Services The Plan provides 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 the Contract Administrator.

The Plan provides 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.

Hospice Care Services The Plan provides 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.

The Plan provides 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 The Plan provides 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 or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide Hospice Care.

Before the patient receives respite care at home, a Home Health Agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an Inpatient Hospice.

Inpatient Hospice Services The Plan provides 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 the 'Inpatient Hospital Services' provision.

Inborn Errors of Metabolism The Plan provides Benefits for metabolic formula and special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by Inborn Error(s) of Metabolism. This benefit is limited to those Members with diseases caused by Inborn Error(s) of Metabolism. For prescription drug coverage contact Express Scripts Member Services at 1-800-595-0817 or www.Express-Scripts.com.

Independent Laboratories The Plan provides Benefits for Diagnostic Services performed by independent laboratories. All services must be ordered by a Provider.

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

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

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

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

- Malabsorption of cow milk-based or soy milk-based infant formula.

Infertility The Plan provides Benefits for Diagnostic Services, procedures, and treatment for Infertility. See the Benefit Summary for coverage requirements and limits that apply.

Basic Infertility:

The Plan provides Benefits for services provided by Network Providers to diagnose and treat infertility.

Comprehensive Infertility and Advanced Reproductive Technology (ART):

The Plan provides Benefits for services incurred by an eligible covered female for infertility if all of the following tests are met:

- A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or a Network infertility specialist, and the Provider who diagnosed the infertility, and it has been documented in the medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than 19 mIU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

Comprehensive Infertility Services by a Network Provider include:

- Ovulation induction with menotropins.
- Intrauterine insemination.

Advanced Reproductive Technology (ART) Services by a Network Provider include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamet intra-fallopian transfer (GIFT)
- Cryopreserved embryo transfers
- Intracytoplasmic sperm injections (ICSI); or ovum microsurgery

Covered ART Benefits:

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations section of the Benefit Booklet:

- Up to 3 cycles and subject to the maximum benefit shown in the Benefit Summary, which only include : IVF, GIFT, ZIFT, or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection (“ICSI”); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the Benefit Summary;
- Payment for charges associated with the care of the an eligible covered person under this Plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse/domestic partner is also covered under this Plan.

Infusion Therapy The Plan provides Benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy Provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.

Inhalation Therapy The Plan provides 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 The Plan provides Benefits for the following Inpatient Hospital services:

- Room and board, including general nursing care, special duty nursing, and special diets, in a semiprivate room or a private room when medically necessary or when the facility offers only private rooms;
- 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, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services;
- Phase I Cardiac Rehabilitation;
- Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law;
- Blood and blood derivatives;
- Prostheses or Orthotic Devices;
- Newborn care, including routine well-baby care.

Benefits for an Inpatient Stay in a Hospital will end with the earliest of the following events:

- You are discharged as an Inpatient;
- You reach any of the limits or maximums shown in your Benefit Summary;
- Your Physician, Hospital personnel, or we notify you that Inpatient care no longer meets our guidelines for continued Hospital admission.

Jaw Joint Disorder Treatment

The Plan covers charges made by a physician, hospital or surgery center for the diagnosis and surgical treatment of jaw joint disorder. A jaw joint disorder is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD).

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a jaw joint disorder.

Manipulative Therapy The Plan provides Benefits for treating acute musculo-skeletal disorders. No Benefits are provided for ancillary treatment such as massage therapy, heat, and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions. Please see your Benefit Summary for limits that apply.

Massage Therapy The Plan provides Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a Covered Provider (Please see definition of Covered Provider.). A massage therapist is not a Covered Provider.

Medical Care The Plan provides Benefits for medical care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits, and pediatric services.

Medical Supplies The Plan provides 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 only the following Mental Health and Substance Abuse services when they are for the active treatment of Mental Health and Substance Abuse disorders. These services must be part of an established plan of treatment and must be performed and independently billed by a Provider acting within the scope of his or her license.

Benefits for Inpatient, Outpatient, and day treatment services for Mental Health and Substance Abuse are provided when you receive them from a Provider. You will receive maximum Benefits for Mental Health and/or Substance Abuse Services when you receive care from Network Providers.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs and Intensive Outpatient Programs services.
- **Online Visits** when available in your area. Covered Services include a visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

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

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or

Any agency licensed by the state to give these services, when we have to cover them by law.

If you receive Provider services from a Community Mental Health Center or Substance Abuse Treatment Facility, services must be:

- Supervised by a licensed Physician, licensed clinical psychologist, licensed clinical professional counselor, or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

You will receive maximum Benefits for Mental Health and/or Substance Abuse services when you receive care from Network Providers.

- Individual and group counseling;
- Family counseling;
- Psychological testing;
- Diagnostic and evaluation services;

- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring an immediate and acute need for treatment;
- Intervention and assessment;
- Room and board, including general nursing;
- Prescription Drugs, biologicals, and solutions administered to Inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, Group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring immediate and acute treatment.

The “Utilization Management” section contains additional information about seeking Mental Health and Substance Abuse services. Please refer to your Benefit Summary for additional information regarding Mental Health and Substance Abuse Benefits.

Nutritional Counseling The Plan provides Benefits for nutritional counseling.

Obstetrical Services and Newborn Care We provide Benefits for prenatal, postnatal and postpartum care, delivery of a newborn, care of a newborn, and complications of pregnancy. Benefits are also provided for routine circumcisions.

Office Visits The Plan provides Benefits for office visits. Certain office visits are subject to a Copayment. Please refer to your Benefit Summary. Office visits to Network Providers are not subject to the Deductible or Coinsurance. Office visits to Non-Network Providers are subject to the Deductible or Coinsurance and will be paid at the Non-Network level of Benefits. Office visits include visits to a Walk-In Center or a retail health clinic. Services at a retail health clinic are limited to basic health care services to Members on a ‘walk-in’ basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by physician’s assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Online Visits When available in your area, your coverage will include online visit services. See the Benefit Summary for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Covered Services include a medical consultation using the internet via a webcam, chat or voice.

Non Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician to Physician consultation

Please refer to the “Telemedicine” provisions as you may have additional or different services available. For Mental Health and Substance Abuse Online Visits, see the “Mental Health and Substance Abuse Services” section.

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

Transplants include:

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

The Plan will not pay any Benefits for any services related to a transplant that the Plan does not cover.

The Plan provides Benefits as follows:

- If both the donor and the recipient are covered Members of ours, the Plan will provide Benefits to cover both patients for organ and tissue transplants;
- If the recipient is a Member under a Plan with the Contract Administrator but the donor is not, the Plan 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 Plan with the Contract Administrator but the donor is a Member, the Plan will not provide Benefits to either the donor or the recipient.

Coverage for the cost of testing for bone marrow donation suitability

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

- A. The covered member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;
- B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;
- C. At the time of the testing, the covered member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

Orthotic Devices The Plan provides Benefits for certain Orthotic Devices, such as orthopedic braces, back or surgical corsets, and splints. Except as specifically covered for diabetics, the Plan does 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 The Plan provides 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 the Contract Administrator to see if you are eligible for Benefits;
- Outpatient educational programs such as diabetes education. Please check with the Contract Administrator to see if you are eligible for benefits.

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

Physical and Occupational Therapy The Plan provides Benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed Provider 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.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Prescription Drugs you get from a retail or mail-order pharmacy would be covered through your pharmacy benefit manager.

Important Details About Prescription Drug Coverage

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

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

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

Precertification

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

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

If precertification is denied you have the right to file an Appeal as outlined in the “Benefit Determination, Payments and Appeals” section of the Certificate of Coverage.

Designated Pharmacy Provider

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

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

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

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

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

Continuity of Prescription Drugs

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

Therapeutic Substitution

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

Preventive and Well-Care Services

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

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

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
Breast cancer;
Cervical cancer;
Colorectal cancer;
High Blood Pressure;
Type 2 Diabetes Mellitus;
Cholesterol;
Child and Adult Obesity.
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. Women’s Preventive: Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - Women’s contraceptives, sterilization treatments, and counseling: Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
 - Breastfeeding support, supplies and counseling; Covered in full when received from an in-Network Provider. Benefits for breast pumps are limited to one pump per year.
 - Screenings and/or counseling, where applicable, for Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
 - Counseling

You may call Member Services using the number on your ID card for additional information about these services or view the federal government’s web sites,

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.

Radiation Therapy The Plan provides Benefits for Radiation Therapy.

Reconstructive Surgeries, Procedures and Services Benefits are available for reconstructive surgeries, procedures and services, unless otherwise excluded in this contract, 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:

1. necessary due to accidental injury; or
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary Health Care to restore or improve a bodily function, or
4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Benefit Booklet
5. for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

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

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

- 1) Mastectomy for Gynecomastia
- 2) Mandibular/Maxillary orthognathic surgery
- 3) Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants
- 4) Port Wine Stain surgery

Skilled Nursing Facility Services The Plan provides Benefits for Inpatient Skilled Nursing Facility services. The Plan does not cover custodial confinement. Please see the Benefit Summary for limits that may apply.

Smoking Cessation The Plan provides Benefits for:

- Follow-up smoking cessation education and counseling.
- Completing an approved smoking cessation program.

Speech Therapy The Plan provides Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed Provider acting within the scope of his/her license.

No Benefits are provided for:

- Deficiencies resulting from mental retardation; or
- Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Spinal Manipulation The Plan provides Benefits for spinal manipulation. See the ‘Manipulative Therapy’ provision for additional information. Please see your Benefit Summary for limits that apply.

Sterilizations and Reverse Sterilizations The Plan provides Benefits for sterilizations and services to reverse voluntarily induced sterility. See the Preventive and Well-Care Services for sterilization services for women.

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 Member Services.

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 Five: Exclusions

This section, along with the “Covered Services” section, explains the types of health care services the Plan will and will not provide Benefits for. The exclusions listed below are in addition to those set forth elsewhere in this Benefit Booklet. Charges you pay for services related to non-Covered Services do not count toward any Deductible, Coinsurance, or out-of-pocket limits. This Plan will not deny, exclude, or otherwise limit coverage for medically necessary health care services, as defined in this contract, if the item or service provided is a covered service and is based on current standards of care and current federal/state laws.

Alternative Medicines or Complementary Medicines The Plan does 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’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), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) The Plan does not provide Benefits for all indications except as described under Autism Services in the “Covered Services” section unless otherwise required by law.

Artificial Hearts The Plan does 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.

Asthma Education The Plan does not provide benefits for asthma education programs.

Benefits Available from Other Sources The Plan does 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 The Plan does not provide benefits for biofeedback.

Blood The Plan does not provide Benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

Commercial Weight Loss Programs Weight loss programs not approved by the Contract Administrator, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Benefit Booklet.

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

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

Cosmetic Services The Plan does 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 The Plan does not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider.

Dental Services The Plan does not provide Benefits for dental services, unless specifically listed as covered in the “Covered Services” section.

Department of Veterans Affairs The Plan does 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 The Plan does not provide Benefits for any drugs, supplies, Providers, medical, or health care services that are Experimental or Investigational. This exclusion includes the cost of all services from a Provider including the cost of all services while you are an Inpatient receiving an Experimental or Investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials are considered Experimental or Investigational.

Facilities of the Uniformed Services The Plan does 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 The Plan does not provide Benefits for non-prescriptive birth control preparations (such as foams or jellies) and over-the-counter contraceptive devices.

Food or Dietary Supplements The Plan does not provide Benefits for nutritional and/or dietary supplements, except as provided in this Benefit Booklet or as required by law. For prescription drug coverage information contact Express Scripts at 1-800-595-0817 or visit www.Express-Scripts.com.

Genetic Testing and Counseling The Plan does not provide Benefits for genetic counseling, except as required by law. The Plan does not provide Benefits for genetic testing, except in accordance with Anthem Medical Policy. Medical technology is constantly evolving and medical policies are subject to change without notice.

Government Institutions The Plan does 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 The Plan does not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities,

equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Infertility The Plan does not provide services related to infertility, except as outlined in the “Covered Services” section.

Leased Services and Facilities The Plan does 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 The Plan does not provide Benefits for rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

Major Disaster, Epidemic, or War In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, the Contract Administrator will make a good faith effort to provide or arrange for Covered Services. The Contract Administrator 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 The Plan does not provide Benefits for massage therapy when services are not part of an active course of treatment and are not performed by a Covered Provider (Please see definition of Covered Provider.). Services by a massage therapist are not covered.

Medical Equipment, Devices, and Supplies

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- c) Non-Medically Necessary enhancements to standard equipment and devices.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

Medically Unnecessary Services The Plan does not provide Benefits for any treatment, services, or supplies that do not meet the definition of Medically Necessary Health Care.

Medicare The Plan 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, the Plan may provide Benefits only for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the Primary Payor, the Plan may pay Benefits as if Medicare had made their primary payments for Medicare Part A and/or Part B, even if you fail to exercise your right to premium free Medicare Part A coverage.

Mental Health, Substance Abuse Treatment and Lifestyle Services The Plan does not provide Benefits for any of the following services or any services relating to:

- Smoking clinics;
- Sensitivity training;
- Encounter Groups;

- Educational programs except as indicated in the “Covered Services” section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for Hospice Care services);
- Activities whose primary purpose is recreational and socialization.

Miscellaneous Expenses The Plan does not provide Benefits for Provider charges to provide required information to process a claim or application for coverage. The Plan does not provide Benefits for any additional costs associated with an Appeal of a claim decision.

Missed Appointments The Plan does 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.

Orthotic Devices The Plan does not provide Benefits for Orthotic Devices unless stated as covered in the “Covered Services” section of this Benefit Booklet.

Personal Comfort Items The Plan does not provide Benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

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

Prescription Drugs

Benefits for prescription drugs obtained through a retail or mail-order pharmacy are provided by Express-Scripts, Inc., the pharmacy benefit manager. To contact Express Scripts Member Services call 1-800-595-0817 or www.express-scripts.com.

Preventive Care The Plan does not provide Benefits for preventive care and well-care services, unless otherwise stated in the “Covered Services” section.

Prostheses The Plan does not provide Benefits for dental Prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes or contain a microprocessor.

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

Residential accommodations Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center.

Routine Foot Care The Plan does not provide Benefits for any services rendered as part of routine foot care.

Services After Your Contract Ends The Plan does not provide Benefits for services that are provided after your Contract ends unless your Group cancels coverage with the Contract Administrator and you are an Inpatient on the Group cancellation date. If you are an Inpatient on the date your Group cancels

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

Services Before the Effective Date The Plan does not provide Benefits for any treatment, services, supplies, medical equipment, or Prostheses rendered to you or received before your individual effective date of coverage. Services you receive during an Inpatient Stay that started before you enrolled are covered only as of your effective date on this Contract. For an Inpatient Stay, care that is provided before your effective date is not covered.

Services by Ineligible Providers The Plan does not provide Benefits for services received from an individual or entity that is not licensed by law to provide Covered Services as defined in this Benefit Booklet. Examples may include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

Services by Relatives or Volunteers The Plan does 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. The Plan does not provide Benefits for services by volunteers, except as outlined in the “Hospice Care Services” provision.

Services Not Listed As Covered The Plan does not provide Benefits for any service, procedure, or supply not listed as a Covered Service in this Benefit Booklet.

Services Related to Non-Covered Services The Plan does not provide Benefits for services related to any non-Covered Service or to any complications and conditions resulting from any non-Covered Service.

Shoe Inserts The Plan does not provide Benefits for shoe inserts.

Speech Therapy The Plan does 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.

Surrogate Mother Services The Plan does not provide Benefits for any services or supplies provided to a person not covered under the Benefit Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Travel Expenses The Plan does not provide Benefits for any travel expenses, whether or not the travel is recommended by a Provider.

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

Waived Cost-Shares Out-of-Network The Plan does not provide Benefits for any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

Workers' Compensation The Plan does 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. The Plan does not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, The Plan does provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

The Plan will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met:**

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

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

Section Six: Benefit Determinations, Payments and Appeals

Benefit Determinations

The Plan Administrator, the Contract Administrator, or anyone acting on the Contract Administrator's 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 Plan. The Contract Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowed Amount. However, you may utilize all applicable Complaint and Appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under your Plan. Your responsibility may take the form of a Coinsurance percentage, a Deductible, or a Copayment amount. Please see your Benefit Summary for the Coinsurance, Deductible and Copayment amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your Coinsurance, Deductible, or Copayment amount directly to the Provider or Hospital or other provider of care. If you have Coinsurance responsibility that is based on a percentage, you will pay your Coinsurance percentage based on the Hospital's or Provider's discounted charge or negotiated amount, or the Maximum Allowed Amount for Providers.

Under certain circumstances, if the Contract Administrator pays the healthcare Provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, the Contract Administrator may collect such amounts directly from you. You agree that the Contract Administrator has the right to collect such amounts from you.

Note: Non-Network Providers can bill you for the difference in their charge and the Maximum Allowed Amount.

All Benefits for Covered Services will be based on any discounted charge for Hospital service or the Maximum Allowed Amount for Providers services.

The Contract Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, Prescription Drugs, Mental Health, 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.

Care Coordination

The Contract Administrator pays In-Network Providers in various ways to provide Covered Services to you. For example, sometimes the Contract Administrator may pay In-Network Providers a separate amount for each Covered Service they provide. The Contract Administrator may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Contract Administrator may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Contract Administrator may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

Payment Innovation Programs

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

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

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

Benefit Levels There are three levels of Benefits under this Plan:

- Preferred Level
- In-Network Level
- Non-Network Level

See your Benefit Summary for cost shares that apply for each level.

Preferred/In-Network Providers If your claim from a Preferred or In-Network Provider is approved, the Plan will pay Benefits directly to the Provider. Except for Copayments, Deductibles, and Coinsurance, you are not required to pay any balances to the Provider for Covered Services until after the Contract

Administrator determines the Benefits that will be paid. Benefits will be paid at the Preferred or In-Network level of Benefits listed on your Benefit Summary.

Non-Network Providers If you receive Covered Services or supplies from a Provider that does not have a written agreement with the Contract Administrator, the Contract Administrator will determine Benefits based on the Provider's eligibility and licensing. If your claim is approved, Benefits will be paid at the Non-Network level of Benefits listed on your Benefit Summary. You will be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Copayment or Deductible. The Contract Administrator cannot prohibit Non-Network Provider's from billing you for the difference in their charge and the Maximum Allowed 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 indicated on your Benefit Summary. In this circumstance, please call the number on the back of your ID card to coordinate care through a Non-Network Provider.

How Your Deductible Works

Each Calendar Year before Benefits can be paid for most Covered Services, you must pay your Deductible. Please refer to your Benefit Summary.

Family Deductible Under family coverage, if the total family expenses for Covered Services exceed two times the individual Deductible, then your family Deductible under this Plan has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without meeting further Deductibles. One family member may not meet the family Deductible amount. The family Deductible amount must be satisfied by at least two family members.

One Deductible For a Common Accident Under family coverage, if two or more family members are injured in the same accident, only one Deductible will apply for all Covered Services resulting from that accident during a Calendar Year.

Copayments and Coinsurance

Copayments and Coinsurance apply after you have satisfied your Deductible. Please see your Benefit Summary for Copayment amounts and Coinsurance amounts and limits. If services are received from a Provider that does not have a written participation agreement with the Contract Administrator there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowed Amount in addition to any applicable Copayment, Coinsurance or Deductible. The Contract Administrator cannot prohibit Non-Network Providers from billing you for the difference in their charge and the Maximum Allowed Amount.

Copayments

For some services, your share of the cost is a fixed dollar amount or a percentage. Copayment amounts do count toward the Coinsurance and Out-of-Pocket limits under this Plan. Please see your Benefit Summary for applicable Copayment amounts.

Coinsurance For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the Coinsurance amount. Once you pay the annual Coinsurance limit, the Plan will pay Benefits at 100% of the Maximum Allowed Amount for Covered Services, for the rest of the Calendar Year.

How Your Coinsurance Limit Works Under family coverage, if the total family Coinsurance expenses exceed two times the individual Coinsurance limit, your family Coinsurance limit under this Plan has

been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without paying further Coinsurance.

Out-of-Pocket Limits

Your annual out-of-pocket expenses for your Copayments, Deductible and Coinsurance are limited. Please refer to your Benefit Summary for Annual Out-of-Pocket Limits that may apply. Once you reach the Annual Out-of-Pocket Limit, no further Copayments, Deductibles or Coinsurance apply for the remainder of the Calendar Year. The Out-of-Pocket Limit does not include your premiums, amounts over the Maximum Allowed Amount, services covered under any vision plan (if applicable), or charges for non-covered services.

Benefit Maximums

Specific benefit maximums for each covered Member may apply for Mental Health and other services. These maximums are listed on your Benefit Summary or in this Benefit Booklet.

Compliance with Laws

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

Confidentiality

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

Statements and Representations

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

Acknowledgement of Understanding

By accepting this Plan you expressly acknowledge your understanding that this Plan constitutes a benefit plan provided through your Group by agreement with the Contract Administrator (Anthem), 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 license permits Anthem to use the Blue Cross and Blue Shield service marks in the State of Maine, and that Anthem is not contracting as the agent of the Association.

You also acknowledge that you have not accepted this Plan based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem will be held accountable or liable to you for any of Anthem's obligations created under this policy. These acknowledgements in no way create any additional obligations whatsoever on the part of Anthem other than those set forth in this Plan.

Severability

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

Benefit Payments

Claims Procedure:

How to Claim Benefits In most instances, Providers will file your claims with the Contract Administrator. However, you may need to submit a claim for reimbursement for services from Non-Network Providers.

To receive claim forms, contact your employer or call the Contract Administrator's Member Services Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

Time Limit for Filing Claims The Contract Administrator must receive proof of a claim for reimbursement for a Covered Service no later than 365 days after that service is received. 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 the Contract Administrator needs to determine your coverage. As a condition for receiving Benefits under this Plan, you or your representative must give the Contract Administrator 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 Plan are personal to you. You cannot assign or transfer them to any other person.

Assignment of Payments You may assign Benefits provided for Covered Services to the Provider of the care.

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

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

Claims Payment:

This section explains how benefits for covered services will be paid. 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. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. Please contact the Member Services department at the telephone number on your ID card for information on obtaining claim forms.

Payment Innovation Programs

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

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

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

Payment of Provider Services

Maximum Allowed Amount

This section describes how the Contract Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on the 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 Plan is the maximum amount of reimbursement the Contract Administrator (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 Plan 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 Plan.

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, the Contract Administrator 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 the determination of the Maximum Allowed Amount. The Contract Administrator's application of these rules does not mean that the Covered Services you received were not Medically Necessary Health Care. It means the Contract Administrator has 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, the Contract Administrator 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.

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

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 Plan or in a special center of excellence/or other closely managed specialty network, or who has a participation contract with the Contract Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for your Plan 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 Member Services for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Contract Administrator and are not in any of the Contract Administrator's 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 Plan will be one of the following as determined by Anthem:

1. An amount based on our Network or Non-Network Provider fee schedule/rate (as required by law), which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data or
2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; 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 equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this product, but contracted for other products with the Contract Administrator are also considered Non-Network. For your Plan, the Maximum Allowed Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between the Contract Administrator 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 the Contract Administrator's 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 Member Services for help in finding a Network Provider or visit the Contract Administrator's website at www.anthem.com.

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

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

Claims Review

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

Member Cost Share

For certain Covered Services and depending on your Plan, 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 Benefit Summary for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Plan 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. Both services specifically excluded by the terms of your Plan and

those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower 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 the Contract Administrator 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, the Contract Administrator 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 the Contract Administrator in advance of obtaining the Covered Service. If the Contract Administrator authorizes a Covered Service so that you are responsible for the Network cost share amounts, you may not be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless the Contract Administrator has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.. Please contact Member Services 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 the Contract Administrator in advance of receiving any Covered Services, and the Contract Administrator authorizes you to go to an available Non-Network Provider for that Covered Service and the Contract Administrator agrees that the Network cost share will apply.

Your plan has a \$45 Copayment for Non-Network Providers and a \$25 Copayment 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 the Contract Administrator has authorized the Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and the plan will be responsible for the remaining balance.

Out-of-State Providers The Contract Administrator cannot prohibit out-of-state Providers from billing you any balance remaining after the Contract Administrator has made the payment based on the maximum allowable amount except as otherwise provided under the BlueCard program.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard[®] Program

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

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

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

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

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

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard[®] Program

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

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan / Employer on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

E. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

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

F. BlueCard Worldwide[®] Program

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

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

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

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

How Claims are Paid with BlueCard Worldwide

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

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

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

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.

The following are non-allowable expenses:

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

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 Allowed 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 Plan Participant 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 Plan Participant, or as the Dependent of an employee or Plan Participant, 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 Plan Participant longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

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

Disability

If your Group coverage terminates with us while you are totally disabled, Benefits for Covered Services directly relating to the condition causing total disability remain available to you until you are no longer disabled, you reach any contract maximums, you are discharged as an Inpatient and you are no longer disabled, or six months from the termination of your Group Contract, whichever occurs first. If you have replacement coverage, the replacement coverage will pay as primary coverage during this time, and we will pay as secondary coverage for the covered expenses directly relating to the condition causing total disability.

Under the Contract, disabled means:

- If you were employed, you are unable to work in your regular and customary occupation because of illness or injury;

- If you were not gainfully employed, you are unable to engage in most normal activities of a person of like age in good health.

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

Special Information If You Become Eligible For Medicare

You must notify the State of Maine's Division of Employee Health & Benefits if you become eligible for premium free Medicare Part A. Failure to notify Employee Health & Benefits 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 Plan will not provide Benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free 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. For more information call Employee Health & Benefits at 1-800-422-4503.

Medicare and End-Stage Renal Disease

When a Plan Participant who is under age 65 becomes eligible for Medicare solely due to End Stage Renal Disease (ESRD), this Plan will be primary only during the first 30 months of Medicare coverage. Thereafter, the Plan will be secondary to Medicare coverage. If an employee or dependent is under age 65 when Medicare eligibility is due solely to ESRD, and he/she subsequently attains age 65, this Plan will be primary for a full 30 months from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary. If an employee or dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, the Plan will be primary for a full 30 months from the date of ESRD disability. Thereafter, Medicare will become primary and the Plan will be secondary.

Note: When the Plan Participant is a COBRA beneficiary, Medicare is the primary payer.

Third-Party Liability: Subrogation and Right of Reimbursement

These provisions apply when we provide health care Benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery from any source because of these injuries or illnesses. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreement characterize or allocate the money you receive as a Recovery, it shall be subject to these provisions. If the services related to your injuries or illness are covered by a capitation fee, we are entitled to the reasonable cash value of the services.

Subrogation

We have a right to recover payments made on your behalf from any party responsible for compensating you for your injuries or illness, up to the total benefit we paid, on a just and equitable basis.

The following provisions apply:

- We have a lien against all or a portion of the benefits that have been paid to you from the following parties, including, but not limited to, the party or parties who caused the injuries or illness, the

insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, you own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness.

- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them. If you have not pursued a claim against a third party allegedly at fault for your injuries by the date that is sixty (60) days before the date on which the applicable statute of limitations expires, we have a right to bring legal action against the at-fault party.
- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid.

Reimbursement

If you, a person who represents your legal interest, or a beneficiary or dependent have obtained a Recovery and We have not been repaid for the benefits We paid on your behalf, We have a right to be repaid from the Recovery up to the total benefit we paid, on a just and equitable basis. The following provisions apply:

- You must reimburse us to the extent of the health insurance benefits paid on your behalf from any Recovery, including but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, you own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness;
- Upon receipt of a Recovery, You or your legal representative must immediately hold in trust the amount recovered in gross that is to be paid to us. The amount recovered in gross is the total amount of your Recovery reduced by your lawyer fees and costs.

Member's Duties

By accepting Plan coverage you agree:

- Your signed application for coverage is your authorization of our rights of subrogation and reimbursement;
- To promptly notify us of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved;
- To cooperate with us in the investigation, settlement and protection of our rights;
- To cooperate with us in exercising our rights by providing all information requested, including copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury to you;
- To notify us if you retain counsel or file a legal action or claim against a third party;
- To notify us of any Recovery you receive as a result of legal action, a claim against a third party, or a claim against your own insurance within 60 days of your receipt of the Recovery.
- To sign documents we deem necessary to protect our rights; and
- To do nothing to prejudice or interfere with our rights.

If you do not comply with the above, we may request the courts to hold you responsible for expenses we incur in enforcing these provisions.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Complaints and Appeals

Complaints

The Contract Administrator's Member 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 Member 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. The Contract Administrator 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, the Contract Administrator 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, the Contract Administrator 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.

The Contract Administrator 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, the Contract Administrator 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, the Contract Administrator 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.

The Contract Administrator 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.

The Contract Administrator 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 Contract Administrator finding, will be shared between the Contract Administrator 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, the Contract Administrator 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, the Contract Administrator 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 Contract Administrator's 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. The Contract Administrator has 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 the Contract Administrator. 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 the Contract Administrator 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 the Contract Administrator and/or bring legal action against the Plan.

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at the Contract Administrator's expense by conference call, video conferencing or other appropriate technology to present your concerns with the 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 the Contract Administrator. 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. If the Plan Participant is not satisfied with the decision issued by the Second Level Appeal panel, the Plan Participant may bring legal action against the Plan.

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, the Contract Administrator shall provide to the Member all information that was used for that finding that is not confidential or privileged.

A Member has the right to:

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

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

External Review Process

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

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by the Contract Administrator, you may make a written request for external review to the Maine 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 the Contract Administrator 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:

- The Contract Administrator 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;
- The Contract Administrator 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 Maine 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 Maine Bureau of Insurance. For more information call the [Maine Bureau of Insurance](#) at 1-800-300-5000.

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. 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.

Legal Action Against The Contract Administrator

No legal action may be brought against the Contract Administrator until the Member or the Member's authorized representative has exhausted the complaint and Appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

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

Section Seven

Definitions

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

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

Ambulatory Surgery Center A facility that meets both of the following requirements:

- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets the Contract Administrator's standards for participation.

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

Annual Out-of-Pocket Limit The limit on the Copayments, Deductible and Coinsurance you pay each year. After you meet the Annual Out-of-Pocket Limit, you pay no further Copayments, Deductible or Coinsurance for the remainder of the calendar year.

Annual Review Date The date set by the Plan Administrator on which the Plan renews each year.

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

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

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

Benefit Booklet The document that specifies the health care Benefits available to Members under this Plan.

Benefits Payments the Contract Administrator makes on your behalf under this Plan.

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year, or the date your coverage ends, whichever occurs first. Each succeeding Calendar Year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

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

Coinsurance The percentage the Plan pays toward the cost of some Covered Services and the percentage you pay.

Community Mental Health Center An institution that meets both of the following requirements:

- Licensed as a comprehensive level Community Mental Health Center; and
- Meets the Contract Administrator's standards for participation.

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

Contract Holder The employer, association, or trust that applies for and accepts this Plan on behalf of its Members.

Copayment A fixed dollar amount or percentage required to be paid by each Member for certain Covered Services under this Plan. Please refer to your Benefit Summary for specific information.

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

Covered Service Services, supplies or treatment as described in this Benefit Booklet. To be a Covered Service the service, supply or treatment must be:

- a. Medically Necessary or otherwise specifically included as a benefit under this Benefit Booklet.
- b. Within the scope of the license of the Provider performing the service.
- c. Rendered while coverage under this Benefit Booklet is in force.
- d. Not Experimental or Investigational or otherwise excluded or limited by this Benefit Booklet, or by any Amendment or rider thereto.
- e. Authorized in advance by us if such preauthorization is required in this Benefit Booklet.

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 Provider 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 Mental 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 Allowed Amount for certain Covered Services before this Plan provides Benefits.

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

Dependent The eligible employee's lawful spouse, children and others as outlined in the "Eligibility, Termination and Continuation of Coverage" section of this Benefit Booklet.

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

Discount Favorable rates or Discounts the Contract Administrator has negotiated with Hospitals and other Providers. 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 the Contract Administrator which helps to lower the Plan costs.

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 pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Effective Date The first day of coverage under this Plan.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the physical or Mental Health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to safely transfer to another Hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the Member’s physical and/or Mental Health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

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

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

Enrollment Period The period following your initial eligibility for enrollment.

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

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

- (a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:
 - (i) cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency and such final approval has not been granted; or
 - (ii) has been determined by the FDA to be contraindicated for the specific use; or
 - (iii) is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or
 - (iv) is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function; or
 - (v) is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

- (b) Any Service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem BCBS. In determining whether a Service is Experimental or Investigational, Anthem BCBS will consider the information described in subsection (c) and assess the following:
- (i) whether the scientific evidence is conclusory concerning the effect of the Service on health outcomes;
 - (ii) whether the evidence demonstrates the Service improves the net health outcomes of the total population for whom the Service might be proposed by producing beneficial effects that outweigh any harmful effects;
 - (iii) whether the evidence demonstrates the Service has been shown to be as beneficial for the total population for whom the Service might be proposed as any established alternatives; and
 - (iv) whether the evidence demonstrates the Service has been shown to improve the net health outcomes of the total population for whom the Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- (c) The information considered or evaluated by Anthem BCBS to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:
- (i) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
 - (ii) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
 - (iii) documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (iv) documents of an IRB or other similar body performing substantially the same function; or
 - (v) consent document(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (vi) the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (vii) medical records; or
 - (viii) the opinions of consulting Providers and other experts in the field.

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

Facility A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, chemical dependency treatment facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Contract Administrator.

Family Planning Agency An agency that meets both of the following requirements:

- Is a delegated Family Planning Agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets the Contract Administrator's standards for participation.

Freestanding Imaging Center An institution that meets both of the following requirements:

- Licensed (where available) as a Freestanding Imaging Center, freestanding diagnostic center, or freestanding radiology center; and
- Meets the Contract Administrator's standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:

- Has a medical staff of Physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an Inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets the Contract Administrator's standards for participation.

Grace Period The 31 days that begins with and follow the due date of an unpaid subscription charge/administrative fees.

Group Your employer.

Home Health Agency An institution that meets both of the following requirements:

- Licensed as a Home Health Agency; and
- Meets the Contract Administrator's standards for participation.

Hospice A facility that meets both of the following requirements:

- Licensed as a Hospice; and
- Meets the Contract Administrator's standards for participation.

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

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

Inborn 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 the Contract Administrator's standards for participation.

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

Inpatient A registered bed patient who occupies a bed in a Hospital, Skilled Nursing Facility, or residential treatment facility. A patient who is kept overnight in a Hospital solely for observation is not considered a registered Inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an Outpatient.

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

Intensive Outpatient Program Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Late Enrollee A Plan Participant or a Dependent family member who requests enrollment under the Contract Holder's Group health plan following the initial Enrollment Period provided under the terms of the plan; or a Plan Participant or Dependent family member who enrolls after 31 days following any of the qualifying life events described in the "Eligibility, Termination, and Continuation of Coverage" section of this Benefit Booklet. A Late Enrollee may only submit an application during the annual Late Enrollee Enrollment Period.

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

Maximum Allowed Amount 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 Plan Participant and all family members who are eligible for coverage and accepted for coverage under this Plan.

Mental Health and Substance Abuse

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

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 the Contract Administrator to furnish health care services under this Plan. Also referred to as Participating Providers.

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

Non-Network Pharmacy Any appropriately licensed Pharmacy, located within the United States that is not a Participating Pharmacy under the terms and conditions of this Benefit Booklet. Also referred to as “Non-Participating Pharmacy”.

Non-Network Providers Health care Providers that do not have a written agreement with the Contract Administrator to furnish health care services under this Benefit Booklet. Also referred to as Non-Participating Providers. Providers who have not contracted or affiliated with the Contract Administrator’s designated Subcontractor(s) for the services they perform under this Plan are also considered Non-Network Providers.

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

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

Outpatient A patient who receives services at a Provider and who is not a registered Inpatient. 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.

Partial Hospitalization Program Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Physician See definition of “Provider.”

Plan or the Plan The State of Maine Health Plan.

Plan Administrator Your Employer.

Plan Participant A covered employee or the employee’s eligible dependent who meets the eligibility requirements described in the Eligibility, Termination and Continuation of Coverage section of this Benefit Booklet. A dependent child may not be a covered dependent of more than one employee, and an employee may not be another employee’s covered dependent.

Plan Year A period of 12 consecutive months beginning on the initial effective date of your Group’s benefit program through its agreement with the Contract Administrator, and 12 consecutive months thereafter beginning on each renewal date of your employer/s health benefit program.

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 duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Booklet. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- 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
- Infusion Providers
- Other Providers that have written participating agreements with the Contract Administrator;
- Other Providers, as required by law.

Physicians

- Doctor of Medicine
- Doctor of Osteopathy

Other Providers:

- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed 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 Providers that have written participating agreements with the Contract Administrator;
- Other Providers as required by law.

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

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

Rural Health Center An institution that meets both of the following requirements:

- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets the Contract Administrator's 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 the Contract Administrator's standards for participation.

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

Specialty Drugs Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injection, infused, oral and inhaled.

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 the Contract Administrator's behalf.

Subscription Charges/Administrative Fees The fees established by the Contract Administrator as consideration for benefits offered under the Plan.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all of the following requirements:

- Licensed or certified as a Substance Abuse Treatment Facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets the Contract Administrator's standards for participation.

Surgical Assistant A Physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified Provider 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 Provider acting within the scope of his or her license that is:

- A generally accepted operative and cutting procedure; or
- 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.

Tier Listing The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

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

- (1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

- (2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

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

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

Walk-In Center / Retail Health Clinic The terms Walk-In Center and Retail Health Clinic mean a free-standing center providing episodic health services without appointments for diagnosis; care; and treatment.

We, Us, Our The Contract Administrator (Anthem).

Section Eight

Federal Notices

Federal Patient Protection and Affordable Care Act Notice:

Access to Obstetrical and Gynecological (ObGyn) Care

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

Additional Federal Notices:

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

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

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

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

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

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

Notice Regarding Breast Cancer Patient Protection Act

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

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

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask

the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

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

Section Nine

Family Medical Leave Act (FMLA)

Family and Medical Leave Act Requirements and Effective Date

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

FMLA was effective on August 5, 1993, for most employers. If a collective bargaining agreement (CBA) was in effect on August 5, 1993, then FMLA became effective on the expiration date of the CBA or February 5, 1994, whichever was earlier.

Reasons for Taking Leave

FMLA leave must be granted for any of the following reasons:

- Care of your child after birth;
- Placement of a child with you for adoption or foster care;
- Care of your spouse, child or parent who has a serious health condition; or
- A serious health condition that makes you unable to work.

Employee Eligibility

To be eligible for FMLA benefits, an employee must:

- Work for a covered employer;
- Have worked for the employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within 75 miles.

Advance Notice and Medical Certification

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

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

Continuation of Health Coverage, Job Benefits, and Protection

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

If you fail to make the payments on a timely basis, the employer can end the coverage during the leave if your payment is more than 30 days late.

Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.

The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Intermittent Leave

Under some circumstances, you may take FMLA leave intermittently which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Where FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval. FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because you are seriously ill and unable to work.

Substitution of Paid Leave

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

Spouses Who Work For the Same Employer

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

Reenrollment After a FMLA Leave and Not Returning After a FMLA Leave

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

Note: See your employer for details about continuing group coverage other than health coverage.

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