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 customer service number on the back of your Member identification card or in your Benefit Booklet.

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 customer service 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 Member identification 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 Bowdoin College 1 Preferred Provider Organization Health Plan.

The benefits described in this Benefit Booklet are those in effect as of January 1, 2015.

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, Contract Administrator, and such other individuals as may be party to or associated with the Plan shall be guided solely by this Benefit Booklet, which is also the Benefit Booklet. It is the intention of the Employer that this document will comply with the applicable provisions of the Employee Retirement Income Security Act of 1974, as amended.

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.

Bowdoin College hopes and expects to be able to continue the 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 Plan Administrator or an officer of the Employer.
Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it’s covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- 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 Contract Administrator’s company and services.
  - The Contract Administrator’s network of doctors and other health care providers.
  - Your rights and responsibilities.
  - The rules of your health care plan.
  - The way your health plan works.
- Make a complaint or file an appeal about:
  - Your Plan
  - Any care you get
  - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don’t understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose a Network Provider primary care Physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your doctors or other 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 care plan that you have agreed on with your doctors or health care Providers.
- Give the Contract Administrator, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include
information about other health and insurance benefits you have in addition to your coverage with the Plan.

- Let the Contract Administrator’s customer service department know if you have any changes to your name, address or family members covered under your Plan.

The Contract Administrator is committed to providing quality benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact the Contract Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your Member identification card.

How to Obtain Language Assistance
We are committed to communicating with our Members about their health plan, regardless of their language. We employ a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of your Member identification card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with Member needs.
Table of Contents

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
This section provides general information about the Plan, such as names and addresses of the Plan Administrator and the Contract Administrator.

Section Two — Eligibility, Termination, and Continuation of Coverage
This section explains how and when you become eligible for coverage, how and when coverage can end, and how and when coverage can continue under this Plan when you are no longer eligible as a Plan Participant.

Section Three — Utilization Management
This section explains the admission review, and individual case management provisions.

Section Four — Covered Services
This section explains the types of health care services included in your Plan.

Section Five — Exclusions
This section lists health care services that are not covered.

Section Six — Benefit Determinations, Payments, and Appeals
This section explains how Benefits are determined, how to file a claim, how the Plan pays approved claims, and how to Appeal a claim denial.

Section Seven — Definitions
This section defines words and phrases that have special meanings.

Section Eight — Statement of ERISA Rights
This section explains your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

Section Nine – Family Medical Leave Act (FMLA)
This section explains your rights under the Family Medical Leave Act.

Section Ten – Health Benefits Coverage Under Federal Law

Claims Information
For questions about Covered Services or claims, please call a Customer Service Representative at the number on your Member identification card. Be sure to have your identification number ready when you call so we can answer your questions promptly.
Section One
General Information

The Bowdoin College Preferred Provider Organization Health Plan is a self-funded health plan governed by ERISA. 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
Bowdoin College

The Plan Effective Date
January 1, 2015 for this Benefit Booklet. The Bowdoin College Preferred Provider Organization Health Plan was originally effective January 1, 1991.

Eligible Classes of Employees

For 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
An eligible employee’s “Eligible Date” for Plan coverage is his or her first day of employment in an eligible classification.

Plan Name and Number
The name of the Plan is the Bowdoin College Preferred Provider Organization Health Plan.

The Plan Number is: 514

Name and Address of Plan Sponsor
The President and Trustees of Bowdoin College
3500 College Station
Brunswick, Maine 04011

Employer Identification Number (EIN) Assigned to Sponsor by the IRS
01-0215213
Type of Coverages 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 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
  Bowdoin College
  Director of Human Resources
  3500 College Station
  Brunswick, Maine 04011-8426
  (207) 725-3837

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 employees 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 January 1 and ending on December 31.

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, Bowdoin College 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, 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 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 Plan Participant?
1. The Plan Participant;
2. The Plan Participant’s legal spouse or domestic partner (For information on spousal/domestic partner eligibility please contact the Employer);
3. The Plan Participant’s/spouse’s or 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;
4. The Plan Participant’s/spouse’s or domestic partner’s unmarried 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 by us on and continuously since his or her 26th birthday.
5. Under Age 65 Retirees of Bowdoin College and their eligible dependents (For information on retiree eligibility please contact the Employer).

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Plan Participant, 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, or age.

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

If an employee and spouse are both eligible for employee coverage, only one will be eligible for coverage with respect to dependents. In addition, the spouse 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.

Bowdoin College will determine the effective date of coverage for the Plan Participant and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call the number on your Identification Card.

The Plan 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; and
- States the period of time 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 after we have accepted your application, you must:

- Notify the Employer;
- File an application; and
- Pay the applicable employee contribution.

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

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 If we receive a newborn child’s application for change:

- Within 31 days from the date of birth, coverage is continuous from the moment of birth. We will collect applicable charges.
- After 31 days from the date of birth, coverage will begin on the Group’s next annual Late Enrollee Enrollment Period.

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

- Within 31 days from the date the child is adopted or placed for adoption with the 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 31 days from the date the child is adopted or placed for adoption with the Plan Participant and/or spouse, coverage will begin on the Group’s next annual Late Enrollee Enrollment Period.

Marriage When the Plan Participant marries, if we receive the spouse’s (and children’s, if applicable) completed application for change:

- Within 31 days from the date of marriage, coverage begins the first of the month that occurs immediately on or after the date we receive the application.
- After 31 days from the date of marriage, coverage will begin on the Group’s next annual Late Enrollee Enrollment Period.

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

- Within 31 days of the date of the court order, coverage will begin on the date of the court order.
After 31 days from the date of the court order, coverage will begin on the Group’s next annual Late Enrollee Enrollment Period.

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

- **Within 31 days of the date the dependent loses coverage**, coverage will begin on the date of application for enrollment.
- **After 31 days from the date the dependent loses coverage**, coverage will begin on the Group’s next annual Late Enrollee Enrollment Period.

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

Annual Late Enrollee 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.

Late Enrollee A Late Enrollee is an employee or a Dependent family member who requests enrollment under this Plan following the initial Enrollment Period provided under the terms of the Plan; or an employee or Dependent family member who enrolls after 31 days following any of the life events described below. A Late Enrollee may only submit an application during the annual Late Enrollee Enrollment Period.

Exception for Late Enrollees A person is not considered a Late Enrollee if he/she incurs a claim under a prior contract or policy that would meet or exceed that contract or policies lifetime limit on all Benefits, and a request for enrollment is made not later than 31 days after a claim is denied in whole or in part due to the operation of a lifetime limit on all Benefits.

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

- Marriage;
- Divorce, legal separation or dissolution of domestic partnership;
- Death of a spouse/domestic partner, or Dependent child;
- Birth, adoption, or placement for adoption;
- Termination or commencement of spouse’s/domestic partner’s employment;
- 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 employee’s spouse or the minor child of the employee or the employee’s spouse;
- A court order is issued changing custody of a child. The effective date of coverage is the date of the court order;
- You have exhausted your Consolidated Omnibus Budget Reconciliation Act (COBRA) Benefits;
- A Dependent satisfying or ceasing to satisfy the requirements for unmarried Dependents;
- Loss of Medicaid.

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 the applicable number of days (31 days in most cases) after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.

**Conditions required for enrollment:**
1. The employee has declined enrollment in writing stating that coverage under other health insurance coverage was the reason for declining coverage;
2. When the employee declined enrollment in employee and/or Dependent coverage, the employee and/or Dependent had COBRA continuation coverage under other health insurance and COBRA continuation coverage under that other insurer has since been exhausted; or
3. If the other coverage that applied to the employee and/or Dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
   a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
   b. Employer contributions towards the other coverage have been terminated; or
   c. loss of coverage under the Cub Care or other children’s health insurance 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 due to a dependent losing eligible dependent status; or
   h. a dependent who has other coverage loses eligibility under that coverage.

You are not required to elect and exhaust COBRA coverage under another plan to enroll in this Plan during a special enrollment period. If you do elect COBRA coverage under another plan, however, you must exhaust your COBRA coverage under that plan before you can elect to participate in this Plan. Special enrollment rights do not apply if you lose other coverage because you failed to pay 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 you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family Members can reenroll in the Plan, provided you apply for reemployment within the timeframe permitted under the Uniformed Services Employment and Reemployment Rights Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage is effective on the effective date of your reemployment.

**Termination of Coverage**

**Termination Date for Employees 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;
- The day the employee ceases to be included in a class of eligible employees;
- The end of the month following the day employment is terminated.

Coverage with respect to a dependent will terminate upon the earliest to occur of the following dates:
- The date on which the employee’s coverage terminates;
- The day the employee’s dependent coverage under the Plan terminates;
- The day the employee ceases to be included in the classes of persons eligible for dependent coverage, including marriage;
- 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 following the day 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 applicable employee contribution 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 employee contribution at your Group rate plus the administration fee.

**Qualifying events include:**
- Death of the employee;
- Termination of the employee’s employment or reduction in hours of employment (other than for gross misconduct);
- Divorce or legal separation from the employee;
- 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; 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 coverage to any of its employees;
• Your premium payment is not received on time. In such case, your COBRA coverage will be retroactively terminated to the first day of the period for which the premium has 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.

Termination of Continuation Coverage
The maximum period for which coverage may be continued is:

18 months - If continuation is due to a voluntary or involuntary termination of employment (other than for gross misconduct) or a reduction in hours.

29 months - If an individual or a qualified beneficiary is totally disabled (as determined under either Title II or Title XVI of the Social Security Act) at the time of termination or reduction in hours of employment and has given notice of the disability before the end of the 18 months, or becomes totally disabled within the first 60 days of COBRA coverage. In either case, the qualified beneficiary must provide notice of the disability within 60 days after the date of the disability determination.

36 months - If continuation is due to any other reason as described previously described in the Qualifying Events subsection, or if a second qualifying event occurs within an 18-month continuation period.

In any event, your continued group coverage under this Plan will end if any of the following events occur:
• Your employer no longer provides this health plan to any of its employees;
• The Contract Administrator does not receive your premium payment within 31 days of the due date. In such case, your COBRA coverage will be retroactively terminated to the first day of the period for which the premium has not been timely paid;
• You become a covered employee under any other group health plan after the date you elect COBRA continuation coverage and that plan does not contain any exclusion or limitation with respect to any pre-existing conditions you have;
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.

If an employee elects continuation coverage after termination of employment or reduction in hours, any dependent who is a qualified beneficiary may extend this coverage for an additional time if another event occurs for which continuation is allowed. However, continuation may never extend for more than 36 months from the date it originally began.

If a qualified beneficiary does not elect continuation coverage, group health coverage will end the date he/she would otherwise become eligible for COBRA.

Note: Coverage is not available through this Plan when the COBRA continuation ends. Beneficiaries nearing the end of COBRA continuation should seek group or individual health coverage from another source. In order to give careful consideration to the possible factors (cost, evidence of insurability, etc.), beneficiaries should begin the search for alternative coverage up to two months before the end of the COBRA continuation.

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

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

You may elect to continue to coverage for yourself and your eligible Dependents (if any) 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 shall be the lesser of:

- The 24-month period 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.
Section Three
Utilization Management

All services you receive are subject to the provisions in this section. Failure to comply with any or all of the requirements listed below will result in a penalty, or in denial or reduction of your Benefits. If you have any questions, please call the number on the back of your Member 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 ContractAdministrator 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 customer service number on the back of your Member identification 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 Member 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 telephone number on the back of your Member 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 Member identification 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 $300 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 Provider Hospital or other Non-Network Provider 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 Member identification 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 Benefit Booklet.

**Note:**

*Maternity Admissions/Newborns’ and Mothers’ Health Protection Act* - 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 Member identification 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.

**Inpatient Mental Health/Substance Abuse Review** Authorization for Inpatient Mental Health and Substance Abuse services must be obtained through the behavioral health care manager. You, your doctor, or the Provider must call for authorization. Unless you have an Emergency Medical Condition, you must call the telephone number on your Member identification card for prior authorization of all Inpatient Mental Health and Substance Abuse services before you receive the services. It is your responsibility to make sure you receive prior authorization for all non-emergency Inpatient Mental Health and Substance Abuse services. If you do not call for prior authorization for Inpatient Mental Health and Substance Abuse services before you receive the services, your Benefits may be reduced by up to $300. Benefits may be denied if it is determined that services received were not medically necessary. A penalty will not be applied to you for medically necessary inpatient facility services from a Network or BlueCard provider.

**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 Physician(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.

**Continuity of Care**
If you are undergoing a course of treatment and the treating Provider withdraws from this network, the Contract Administrator will notify you of the termination. You may be allowed to continue receiving care from the withdrawing Provider for a period of 60 days from the date of notice of termination or through the end of postpartum care if you are in the second trimester of a pregnancy, if the Provider:

- Agrees to accept the same rates of reimbursement that were in effect prior to the date of termination;
- Agrees to adhere to the Contract Administrator’s applicable quality assurance standards and to provide the Contract Administrator with the necessary medical information related to the care provided you; and
- Agrees to adhere to the Contract Administrator’s policies and procedures.

**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 Member identification 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 a PPO Member.
- Have your Member identification card handy. They may ask you for your group number, Member identification number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member identification 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.
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 or Investigational services and new technology on medical policy developed by Anthem. 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, information found in the following subsections in this Benefit Booklet: Anthem Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in the “Utilization Management” section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

Acupuncture The Plan provides Benefits for acupuncture. Please refer to your Benefit Summary for limits that may apply.

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 the Contract Administrator requires 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 the Contract Administrator. When using an air ambulance, the Contract Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Contract Administrator selects, the Non-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 the Contract Administrator 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.

The Plan provides 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, the Contract Administrator 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.

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.

Chiropractic Care The Plan provides Benefits for chiropractic care. See the ‘Manipulative Therapy’ provision for additional information. Please see your Benefit Summary for limits that apply.
Clinical Trials
Benefits include coverage for services 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 a Network Provider to maximize your Benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Experimental or Investigational as defined by this Plan. All other requests for clinical trials services 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. The Contract Administrator reserves the right to exclude any of the following services:

   i. The Investigational item, device, or service, itself; 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;
   iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
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 prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis.

**Dental Procedures** The Plan provides 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, can not 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; and
- 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 six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later; and
- Repairing or replacing dental Prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.

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 Member 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.

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

If you are admitted to the Hospital from the emergency room, the emergency room Copayment is waived. You or a designated person should contact your Physician within 48 hours from the time you are admitted. If you do not contact your Physician, you or someone you designate should call the telephone number listed on your Member identification 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.

**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.

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

**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.

**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 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  The Plan provides 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 must be covered per state law. Inpatient Benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **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; and
  - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- 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 they must be covered 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; and
- 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.

**Morbid Obesity** The Plan provides limited Benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required. The Plan does not provide Benefits for weight loss medications.

**Nutritional Counseling** The Plan provides Benefits for nutritional counseling when required for a diagnosed medical condition.

**Obstetrical Services and Newborn Care** The Plan provides Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. The Plan does not provide Benefits for routine circumcisions.

**Office Visits** The Plan provides Benefits for office visits. 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 not subject to the Deductible and will be paid at the non-network level of Benefits. Office visits include visits to a Walk-In Center. Office visits include visits to 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, coverage or payment questions; Requests for referrals to doctors outside the online care panel; Benefit precertification; and Physician to Physician consultation.

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.

No other organ or tissue transplant is covered. 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.

If the transplant is covered under the Plan, Benefits are available for follow-up care, including immuno-suppressant therapy.

If the transplant is covered under the Plan, Benefits are available for certain travel expenses to the transplant program provider. The transplant program provider is the Physician performing the transplant and/or the Hospital where the transplant is performed. While traveling to and from the transplant program provider, and if the transplant program provider is located 50 or more miles from the recipient’s home, the following Benefits are Covered Expenses:

a. Transportation is limited to a maximum of the cost of a round-trip coach air fare to the transplant program provider;
b. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
c. Hotel accommodations up to $75 per day at hotels should you be released to an Outpatient facility for Medically Necessary post-surgical care from the transplant program provider;
d. Hotel accommodations up to $75 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan; and
e. Daily meals and other reasonable and Necessary Services and Supplies for you and your travel companion up to an allowance of $75 per person per day.
Benefits are not provided for:

a. Travel, lodging, and other charges for your travel companion other than to accompany you to and from the transplant program provider;
b. Charges in connection with the travel allowance that are not related to your travel to and from the transplant program provider except for charges for your treatment while at the transplant program provider;
c. Charges for the repair or maintenance of a motor vehicle;
d. Personal expenses incurred for the maintenance of your or your travel companion’s residence. Examples of these are child care costs, house sitting costs, or kennel charges;
e. Reimbursement of any wages lost by you or your travel companion; and
f. The services and medical expenses incurred by a donor (except as specified above) as a result of such transplant procedure.

Coverage for the cost of testing for bone marrow donation suitability
The Plan provides coverage for laboratory fees up to $150 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; and

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.

This benefit is limited to one test per lifetime.

Orthotic Devices The Plan provides Benefits for certain Orthotic Devices, such as orthopedic braces, back or surgical corsets, and splints. 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; and
• Outpatient educational programs such as diabetes and asthma 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. Benefits are subject to a combined Calendar Year limit as described on your Benefit Summary. 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  This Plan covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Prescription Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Prescription Drug and administers it to you. Benefits for Prescription Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Prescription Drugs) are not covered under this section. Benefits for those Prescription Drugs are described in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit. Also, if Prescription Drugs are covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, they will not be covered under this benefit.

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 Provider may be asked to give more details before the Contract Administrator can determine if the Prescription Drug is Medically Necessary. The Contract Administrator may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of its Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Committee.
Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. The Contract Administrator will contact your Provider to get the details the Contract Administrator needs to decide if prior authorization should be given. The Contract Administrator will give the results of its decision to both you and your Provider.

If prior authorization is denied you have the right to file an Appeal as outlined in the “Your Right to Appeal” section.

For a list of Prescription Drugs that need prior authorization, please call the phone number on the back of your Member 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 promise coverage under this Plan. Your Provider may check with the Contract Administrator to verify Prescription Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Prescription Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Prescription Drug before the Contract Administrator will cover another. The Contract Administrator checks certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Provider decides that a certain Prescription Drug is needed, prior authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Providers about alternatives to certain prescribed drugs. The Contract Administrator may contact you and your Provider to make you aware of these choices. Only you and your Provider can determine if the therapeutic substitute is right for you. The Contract Administrator has a therapeutic Prescription Drug substitutes list, which the Contract Administrator reviews and updates from time to time. For questions or issues about therapeutic Prescription Drug substitutes, call Customer Service at the phone number on the back of your Member identification card.

Prescription Drug Benefits at a Retail or Home Delivery (Mail Service) Pharmacy

See the Benefit Summary for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor’s office, home care visit, or outpatient Facility) are covered under the “Prescription Drugs Administered by a Medical Provider” benefit. Please read that section for important details.

Your Plan also includes Benefits for Prescription Drugs you get at a retail or mail order Pharmacy. The pharmacy Benefits available to you under this Plan are managed by the Contract Administrator’s Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Contract Administrator contracts to manage your pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a home delivery (mail service) Pharmacy, and provides clinical management services.
The management and other services the PBM provides include, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary), establishing a network of retail pharmacies, and operating a Home Delivery (Mail Service) Pharmacy. The PBM, in consultation with the Contract Administrator, also provides services to promote and enforce the appropriate use of pharmacy Benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Prescription Drug interactions or Prescription Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Customer Service telephone number on your Member identification card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Contract Administrator can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

As described in the “Prescription Drugs Administered by a Medical Provider” section, Prescription Drug Benefits may depend on reviews to decide when Prescription Drugs should be covered. These reviews may include prior authorization, step therapy, use of a Prescription Drug list, therapeutic substitution, day / supply limits, and other utilization reviews. Your Network Pharmacy will be told of any rules when you fill a prescription, and will be also told about any details the Contract Administrator needs to decide Benefits.

Specialty Pharmacy Network
The PBM’s Specialty Pharmacy Network is available to Members who use Specialty Drugs.

“Specialty Drugs” are prescription legend drugs which:

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

You may obtain the list of Network Specialty Pharmacies and covered Specialty Drugs by calling the Customer Service telephone number on your Member identification card or review the lists on the Contract Administrator’s website at [www.anthem.com](http://www.anthem.com).

Covered Prescription Drug Benefits

- Prescription legend drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
• Oral contraceptive Prescription Drugs are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.

• Certain supplies and equipment obtained by Home Delivery (Mail Service) or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Plan to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Home Delivery (Mail Service) or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug Benefits.

• Self-administered injectable Prescription Drugs. These are Prescription Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Prescription Drugs that need Provider administration and/or supervision are covered under the “Prescription Drugs Administered by a Medical Provider” benefit.

• Flu Shots (including administration). These products will be covered under the “Preventive Care” benefit.

• Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the “Preventive Care” benefit. Please see that section for further details.

Non-Covered Prescription Drug Benefits Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

   If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

3. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

4. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

5. **Delivery Charges** Charges for delivery of Prescription Drugs.

6. **Drugs Given at the Provider’s Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the “Error! Reference source not
found.” section, or Drugs covered under the “Error! Reference source not found.” benefit – they are Covered Services.

7. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at [www.anthem.com](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the “Prescription Drug List” in the section “Prescription Drug Benefits at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.

8. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

9. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.

10. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

11. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)

12. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the prescription drug benefit at a retail or home delivery (Mail Order) Pharmacy benefit may be covered under the Durable Medical Equipment and Medical Devices benefit. Please see that section for details.

13. **Items Covered Under the “Error! Reference source not found.” Benefit** Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the ‘Allergy Services’ benefit. Please see that section for details.

14. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

15. **Non-approved Drugs** Drugs not approved by the FDA.

16. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

17. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

18. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under federal law with a Prescription.

19. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

20. **Weight Loss Drugs** Any Drug mainly used for weight loss.

**Deductible/Coinsurance/Copayment**

Each Prescription Order may be subject to Coinsurance/Copayment. If the prescription order includes more than one covered Prescription Drug, a separate Coinsurance/Copayment will apply to each covered Prescription Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowed Amount. Please see the Benefit Summary for any applicable Coinsurance/Copayment. If you receive
Covered Services from an Out-of-Network Pharmacy, a Coinsurance/Copayment amount may also apply.

Days Supply
The number of days supply of a Prescription Drug that you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Benefit Summary.

Formulary
The Plan follows a drug formulary in determining payment and Covered Services. You will be responsible for an additional Copayment amount depending on whether a formulary or non-formulary drug is obtained. Please see the Benefit Summary.

Tiers
Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug has been classified by the Plan as a first, second, or third “tier” Prescription Drug. The determination of tiers is made by the Plan is based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other Prescription Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 drugs have the lowest Copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

- Tier 2 drugs will have a higher Copayment than those in tier 1. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

- Tier 3 drugs will have a higher Copayment than those on tier 2. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Special Programs
From time to time the Contract Administrator or the PBM may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic drugs, home delivery (mail service) Prescription Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

Payment of Benefits
The amount of Benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, an Out-of-Network Pharmacy, or the PBM’s Home Delivery (Mail Service) Program. It is also based upon which Tier the Contract Administrator has classified the Prescription Drug. Please see the Benefit Summary for the applicable amounts, and for applicable limitations on number of days supply.

The Contract Administrator retains the right at the Contract Administrator’s discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.
The amounts for which you are responsible are shown in the Benefit Summary. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Copayment/Coinsurance for which you are responsible.

Your Copayment(s)/Coinsurance amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through the PBM’s Home Delivery (Mail Service), you are responsible for all Copayment/Coinsurance amounts.

For Covered Services provided by an Out-of-Network Pharmacy, you will be responsible for the amount(s) shown in the Benefit Summary. This is based on the Maximum Allowed Amount.

**How to Obtain Prescription Drug Benefits**

How you obtain your Benefits depends upon whether you go to a Network or an Out-of-Network Pharmacy.

**Network Pharmacy** – Present your written Prescription Order from your Physician and your Member identification card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Copayment/Coinsurance amounts. If you do not present your Member identification card, you will have to pay the full retail price of the Prescription Drug. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to the Plan with a written request for refund.

**Specialty Drugs** - You or your Physician can order your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the Customer Service telephone number on the back of your Member identification card. If you or your Physician orders your Specialty Drugs from a Specialty Network Pharmacy, you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician’s office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

**Out-of-Network Pharmacy** – You are responsible for payment of the entire amount charged by the Out-of-Network Pharmacy, including an Out-of-Network Specialty Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the Contract Administrator or from the Employer. You must complete the top section of the form and ask the Out-of-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to the Plan or the PBM. The itemized receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient’s name;
- Prescription number;
- Date the Prescription was filled;
- Name of the Prescription Drug;
- Cost of the Prescription; and
- Quantity of each covered Prescription Drug or refill dispensed.
You are responsible for the amount shown in the Benefit Summary. This is based on the Maximum Allowed Amount as determined by Anthem or the PBM’s normal or average contracted rate with network pharmacies on or near the date of service.

**The Home Delivery (Mail Service) Program** – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written Prescriptions from your Physician, or have your Physician fax the Prescription to the PBM’s Home Delivery (Mail Service). Your Physician may also phone in the Prescription to the PBM’s Home Delivery (Mail Service) Pharmacy. You will need to submit the applicable Coinsurance and/or Copayment amounts to the PBM’s Home Delivery (Mail Service) when you request a Prescription or refill.

**Preventive and Well-Care Services** We provide Benefits for preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead Benefits will be considered under the Diagnostic Services benefit and subject to the coinsurance and/or deductible to your Plan.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member when provided by a Network Provider, if applicable to your plan. That means Anthem pays 100% of the Maximum Allowed Amount. There will be no balance billing when a Network Provider is used. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.
   Examples of these services include:
   - Breast cancer screening;
   - Cervical cancer screening;
   - Colorectal cancer screening;
   - Tobacco use and cessation interventions;
   - Alcohol misuse screening and counseling;
   - High Blood Pressure screening;
   - Type 2 Diabetes Mellitus screening;
   - Cholesterol screening; and
   - Child and Adult Obesity screening and counseling.

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 procedures, and counseling: This includes Generic and single-source brand name drugs for oral contraceptives, as well as injectable contraceptives and patches at no cost share. Please use your Prescription Drug benefit when available. Contraceptive services such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Note: Multi-source brand drugs will be covered under the Prescription Drug benefit and apply the applicable cost share.
   - Well-woman visits.
   - Breastfeeding support, supplies and counseling; Covered in full when received from an in-network provider.
   - 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. Routine eye care services: 1 annual exam up to age 18; 1 exam every two years thereafter.


**Radiation Therapy** The Plan provides Benefits for Radiation Therapy.

**Reconstructive Surgeries, Procedures and Services** Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:
1. necessary due to accidental injury;
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury;
3. Medically Necessary Health Care to restore or improve a bodily function;
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; or
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.

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

Please see your Benefit Summary for applicable Copayment, Coinsurance, Deductibles, limitations, and maximums that apply.

**Speech Therapy** The Plan provides Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined Calendar Year limit as described on your Benefit Summary. 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.

**Sterilizations** The Plan provides Benefits for sterilization services for women. Please see Preventive Care for details.

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

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

**Temporomandibular Joint Disorders (TMD) and Orthognathic Surgery**
Benefits are provided for treating temporomandibular joint disorders. Benefits are subject to the Calendar Year limit indicated on your Benefit Summary.

Benefits are provided for treating:
- Temporomandibular disc displacement with or without reduction,
- Dislocation of the temporomandibular disc,
- Capsulitis or synovitis of the temporomandibular joint,
• Osteoarthrosis and/or osteoarthritis of the temporomandibular joint,
• Polyarthritides of the temporomandibular joint,
• Ankylosis of the temporomandibular joint, and
• Myofascial pain of the muscles of mastication, myositis, spasm or trismus, protective muscle splinting, contracture and tension-type headaches involving the jaw muscles.

Benefits are available in three categories of service - diagnostic, evaluative, and therapeutic. There are specific exclusions in each category.

The following diagnostic services are covered:
• Complete history and physical examination by the Provider and/or upon consultation with a professional specializing in the diagnosis and treatment of TMD, and
• Laboratory and/or diagnostic imaging and/or other recognized diagnostic tests when ordered by the treating Professional to make a specific diagnosis.

Benefits are not provided for the following:
• MRI of temporomandibular joint,
• Jaw tracking device,
• Occlusal analyzing devices, or
• Surface electromyogram analysis.

The following evaluative services are covered:
• Tests or procedures designed to measure loss of normal function, and
• Tests or procedures designed to evaluate the level of pain.

The following therapeutic services are covered:
• Therapeutic approaches designed to address the specific disorder identified,
• Supportive patient education,
• Pharmacologic pain control,
• Physical therapy modalities including: moist heat, ultrasound, EMS, temporomandibular joint mobilization and distraction,
• Nocturnal flat plane stabilization splints designed and monitored by a Professional approved by the Contract Administrator,
• Surgical removal of temporomandibular joint implants, and
• Other invasive surgical procedures, only when conservative treatments have failed or when directed at specific organic diagnoses for which surgery is the recommended treatment.

Benefits are not provided for the following therapies:
• Electromyogram feedback,
• Cranial-sacral therapy, or
• Myofascial release therapy.

Wigs The Plan provides Benefits for wigs when necessary following cancer treatment.
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.

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), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), and iridology-study of the iris.

Applied Behavior Analysis The Plan does not provide Benefits for Applied Behavior Analysis.

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.

Autism Spectrum Disorder The Plan does not provide Benefits for Autism Spectrum Disorders.

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 Care, or convalescent care, whether or not recommended or performed by a Provider.

**Dental Services** The Plan does not provide Benefits for Orthognathic Surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in the “Covered Services” section.

**Department of Veterans Affairs** 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.

**Early Intervention Services** The Plan does not provide Benefits for Early Intervention Services.

**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. Please see “Clinical Trials” in the Covered Services section for additional information.

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

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

**Genetic Testing and Counseling** 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.

**Hearing Care** The Plan does not provide Benefits for hearing aids, or for hearing examinations except for screening Members under the age of 19 years or when related to injury or disease.

**Infertility** The Plan does not provide Benefits for Diagnostic Services, procedures, treatment or other services related to Infertility. This exclusion also applies to drugs used to enhance fertility. The Plan does not provide Benefits for costs associated with achieving pregnancy through surrogacy.

**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 maintenance services, treatments or therapy.

**Major Disaster, Epidemic, or War** In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, 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.

**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 Medicare 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 Medicare 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.

Orthognathic Surgery The Plan does not provide Benefits for Orthognathic Surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.

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.

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.
**Routine Circumcisions** The Plan does not provide Benefits for routine circumcisions.

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

**Services After Your Coverage Ends** The Plan does not provide Benefits for services that are provided after your coverage ends.

**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 Plan. 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.

**Sex Changes** The Plan does not provide Benefits for any services related to any transsexual operation.

**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.

**Sterilizations and Reverse Sterilizations** The Plan does not provide Benefits for sterilizations for men, or for any services to reverse voluntarily induced sterility, except as required under federal law.

**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.

**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; and
- 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.

**Benefit Levels** There are two levels of Benefits under this Plan:

- **Network Providers** If your claim from a Network Provider is approved, the Plan will pay Benefits directly to the Network 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 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 Member identification 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.

When you receive Covered Services during the last three months of the Calendar Year and charges for these Covered Services are applied toward that year’s Deductible, then these same charges will also be applied toward the Deductible for the following year.

**Family Deductible** Under family coverage, if the total family expenses for Covered Services exceed two times the individual Deductible, then your family Deductible under this 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 employee contribution payments, amounts over the Maximum Allowed Amount, services covered under any vision plan (if applicable), or charges for non-Covered Services.

**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 with applicable federal laws or the relevant laws of the state of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

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

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

**Severability**
If any term or provision in this 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 Customer Service Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

**Time Limit for Filing Claims** The Contract Administrator must receive proof of a claim for reimbursement for a Covered Service no later than 365 days after that service is received. 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.

**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 is not required to allow non-compliance of that provision or any other provision at any time, in any case.

**Examination of Insured** To ensure that all claims are valid, the Contract Administrator may require the 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. You will receive maximum Benefits when you receive services from Network Providers. The Contract Administrator reserves the right to pay Benefits to another person if so ordered by a court of competent jurisdiction. You have the right to Appeal as outlined later in this section.

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.
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 Customer Service 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 Customer Service for help in finding a Network Provider or visit the Contract Administrator’s website at www.anthem.com.

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

**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.

**For Prescription Drugs:** The Maximum Allowed Amount for Prescription Drugs is the amount determined by the Contract Administrator using Prescription Drug cost information provided by the pharmacy benefits manager (PBM).

**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 BenefitSummary for your cost share responsibilities and limitations, or call Customer Service 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 Customer Service for Authorized Services information or to request authorization.

Example:
You require the services of a specialty Provider; but there is no Network Provider for that specialty in your service area. You contact 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 Programs**

**Out-of-Area Services**
The Contract Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of the Contract Administrator’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated national account arrangements available between the Contract Administrator and other Blue Cross and Blue Shield licensees.
Typically, when accessing care outside the Contract Administrator’s service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare providers. The Contract Administrator’s payment practices in both instances are described below.

**BlueCard® Program**

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, the Contract Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the Contract Administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to the Contract Administrator.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Contract Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Contract Administrator would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if the Contract Administrator pays the healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, 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.
Non-Participating Healthcare Providers Outside the Contract Administrator’s Service Area

Your Liability Calculation

When covered healthcare services are provided outside of the Contract Administrator’s service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue’s nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, the Contract Administrator may use other payment bases, such as billed covered charges, the payment that would have been made if the healthcare services had been obtained within the Contract Administrator’s service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Plan will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

Pharmacy Benefit Management

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

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

Payment for Prescription Drug Claims

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

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

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

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

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

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

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by the Contract Administrator using Prescription Drug cost information provided by the pharmacy benefits manager (PBM).

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

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

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

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

The contract with primary responsibility provides full Benefits for Covered Services as if there were no other coverage. The contract with secondary responsibility may provide Benefits for Covered Services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or other 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 2.

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 6 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.

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

You must notify the Contract Administrator if you become eligible for premium free Medicare Part A. Failure to notify the Contract Administrator could result in retroactive benefit adjustments if Medicare would have been or is the primary payer. You may choose to continue your coverage once you are eligible for premium free Medicare Part A or 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 or 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.

**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.

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

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

The Contract Administrator also has subrogation rights against your own insurance, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy.

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

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

By accepting Plan coverage you agree:
- Your signed application for coverage is your authorization of the Contract Administrator’s right of subrogation;
- To notify the Contract Administrator of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- To notify the Contract Administrator of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- To cooperate with the Contract Administrator in exercising our right of subrogation by providing all information requested;
- To sign documents the Contract Administrator deems necessary to protect our rights; and
- To do nothing to interfere with these subrogation rights.
If you do not comply with the above, you may be responsible for expenses the Contract Administrator incurs in enforcing our subrogation rights.

**Recovery**
The Contract Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Contract Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Contract Administrator may not provide you with notice of overpayments made by the Contract Administrator or you if the recovery method makes providing such notice administratively burdensome.

**Complaints and Appeals**

**Complaints**
The Contract Administrator’s Customer Service Representatives are ready to help Members resolve complaints about claims processing (including a denial, reduction, or termination of a Plan Benefit and a failure to provide or make payment (in whole or in part) for a Plan Benefit), a retroactive cancellation of coverage (rescission), benefit choices, enrollment, or health care given to you by your Provider. A Customer Service Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. 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 benefit determination within one working day after we get the request. The review will be done by the person who made the adverse benefit 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 his or her 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.

The decision on an adverse benefit determination will include:
- Information sufficient to identify the claim;
- A statement of the specific reason(s) for the adverse benefit determination;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the Plan procedures and time limits for appeal of the decision, external review rights, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the Plan’s Appeals procedures;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Member’s medical
circumstances; or (b) a statement that such explanation will be provided at no charge upon request;

- If the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard;
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims; and
- Contact information for the DOL’s Employee Benefits Security Administration and any applicable state consumer assistance program.

**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 benefit 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 benefit 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 benefit 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 for a full and fair review. 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. You have the right to review information relevant to the claim and the claim file and to present evidence and testimony. Upon request and free of charge you will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim. If the advice of a medical or vocational expert was obtained in connection with the first benefit decision, the names of each such expert shall be provided on your request, regardless of whether the advice was relied on by the Plan. Before issuing a final decision that is based on a rationale that was not included in the initial determination, the Plan will provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the final internal adverse benefit determination to give the you a reasonable opportunity to respond. If any new or additional evidence was considered, relied upon, or generated in deciding the claim, you will be provided with that evidence sufficiently in advance of the due date for filing an Appeal so that you have the opportunity to respond the additional evidence.

Appeal of a first decision or finding must be sent to within one-hundred-eighty (180) calendar days of the date the first decision or finding was made, except in that a decision by the Plan to reduce or terminate an initially approved course of treatment must be filed within thirty (30) calendar days of your receipt of notification of the decision or 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. Failure to comply with the deadlines may cause you to forfeit any right to further review of an adverse decision under these procedures or in court.

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 and who are required to consult with a medical expert in certain situations. The review will take into account all information submitted by you, whether or not presented or available at the first benefit determination. 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:**

- Information sufficient to identify the claim;
- 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 finding;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
• A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;

• A reference to the evidence or information used as the basis for the finding, including reference to the specific Plan provision(s) on which the decision is based and 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. If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Member’s medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request. Where a Member had already sent in a written request for the review criteria used by the Contract Administrator in giving its first adverse benefit determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision;

• Contact information for the Department of Labor’s Employee Benefits Security Administration and any applicable state consumer assistance program; and

• The notice must advise of any additional appeal rights, the process and time limit for exercising those rights, and the right to sue in federal court after exhausting the Plan’s Appeals procedures. Notice of external review rights must be provided to the Member and a description of the process for sending in a written request for second level Appeal review.

When the decision 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 benefit 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 Appeal 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.

**Legal Action Against Anthem BCBS**

No legal action may be brought against the Plan 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 adverse benefit determination notice.
Section Seven
Definitions

This section explains the meaning of some of the words in this Benefit Booklet and other industry terms that may be of assistance to you. 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 coverage 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.

**Benefit Summary** The Benefit Summary gives you information on benefit levels, Deductibles, Copayments, Coinsurance, and maximums that apply to your 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 Administrator** Anthem Blue Cross and Blue Shield.

**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:
- Medically Necessary Health Care or otherwise specifically included as a Benefit under this Benefit Booklet.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Benefit Booklet is in force.
- Not Experimental or Investigational or otherwise excluded or limited by this Benefit Booklet, or by any Amendment or rider thereto.
- Authorized in advance by us if such preauthorization is required under 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 laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

**Dependent** The eligible employee’s lawful spouse, eligible domestic partner, 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.

**Employer** The Employer is Bowdoin College, Brunswick, Maine.

**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 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.
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;

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

(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;

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

(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;

(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;

(vii) medical records; or

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

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

**Family Planning Agency** An agency that meets both of the following requirements:
- Is a delegated Family Planning Agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets the Contract Administrator’s standards for participation.

**FDA Treatment Investigational New Drugs** Treatment Investigational New Drugs is a United States regulation used to make promising new drugs available to desperately ill patients as early in the drug development process as possible.

**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.

**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 or any other state 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.

**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 Prescription Drug** A Prescription Drug that is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.

**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 (Medical Necessity)** 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 Pharmacy Any Pharmacy, located within the United States, acceptable as a participating Pharmacy by the Contract Administrator to provide covered Prescription Drugs to Members under the terms and conditions of this Benefit Booklet. Also referred to as “Participating Pharmacy.”

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.

Pharmacy Any retail establishment operating under a license and in which a registered pharmacist dispenses Prescription Drugs.

Pharmacy and Therapeutics Committee The Contract Administrator’s national committee made up of Physicians and other experts in medicine and Pharmacy.
Physician  See definition of “Provider.”

Plan or the Plan  Bowdoin College Preferred Provider Organization 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. The Bowdoin College Plan Year begins January 1st and ends December 31st.

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

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

Provider  A 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 Benefit 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 Member identification 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 Health and 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 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;
- 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 Drug** The term “Specialty Drug” means prescription legend drugs which:
- are approved to treat limited patient populations, indications or conditions;
- are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- have limited availability, special dispensing and delivery requirements, and/or require additional patient support- any or all of which make the Drug difficult to obtain through traditional pharmacies.

**Subcontractor** An organization or entity that provides particular services in specialized areas of expertise. Examples of 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.

**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.

**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

3. 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.

**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
ERISA Rights

You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine without charge at the plan administrator’s office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the United States Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, you can take steps to enforce the rights explained above. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a daily penalty fee until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for Benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section Six) you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits and Security Administration, U.S. Department of Labor, JFK Federal Building, 15 New Sudbury Street, Room 575, Boston, MA 02203 (617-565-9600) or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.
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.

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**

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 or physical examination.

**Note:** See your employer for details about continuing group coverage other than health coverage.
Section Ten
Health Benefits Coverage Under Federal Law

Choice of Primary Care Physician
The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Contract Administrator’s network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Member identification card or refer to the Contract Administrator’s website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care
You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Contract Administrator’s 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 or 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 Member identification card or refer to the Contract Administrator’s website, www.anthem.com.

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 (e.g., your Physician, nurse midwife, or physician assistant), 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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on Precertification, contact your Plan Administrator.

Also, under federal law, plans may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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 Benefit Summary.

If you would like more information on WHCRA benefits, call your Plan Administrator.

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 your Employer or Plan Administrator 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/visit limits on medical/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/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/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.

Special Enrollment Notice
If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within 31 days after your or your Dependents’ other coverage ends (or after the Employer stops contributing toward the other coverage).

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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible employees and Dependents may also enroll under two additional circumstances:

- the employee’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on your Member identification Card, or contact your Plan Administrator.
## Index

### A

- Adoption .................................................. 4
- Allergy Testing and Injections .................................................. 17
- Alternative Medicines .................................................. 40
- Ambulance Service .................................................. 18
- Ambulatory Surgery Centers .................................................. 19
- Amendment .................................................. 64
- Anesthesia Services .................................................. 19
- Annual Late Enrollee Enrollment Period .................................................. 5
- Annual Reports .................................................. 49
- Annual Review Date .................................................. 64
- Appeal .................................................. 64
- Appeal of Medical Necessity .................................................. 12
- Appeals .................................................. 46
- Artificial Hearts .................................................. 40

### B

- Benefit Determinations .................................................. 46
- Benefit Levels .................................................. 46
- Benefit Payments .................................................. 49
- Benefits Available from Other Sources .................................................. 40
- Birth .................................................. 4
- Blood .................................................. 40
- Blood Transfusions .................................................. 19

### C

- Chemotherapy Services .................................................. 19
- Chiropractic Care .................................................. 19
- Chiropractor .................................................. 65
- Claims Payment .................................................. 50
- Claims Procedure .................................................. 49
- Clinical Trials .................................................. 20
- COBRA .................................................. 7
- Coinsurance .................................................. 47, 65
- Complementary Medicines .................................................. 40
- Compliance with Laws .................................................. 48
- Confidentiality .................................................. 48
- Continuation of Coverage .................................................. 7
- Continued Inpatient Stay Review .................................................. 13
- Contraceptives .................................................. 21
- Contribution To The Plan .................................................. 2
- Coordination of Benefits .................................................. 56
- Copayment .................................................. 47, 65
- Cosmetic Services .................................................. 41, 65
- Court Order Changing Custody .................................................. 4, 5
- Covered Services .................................................. 17, 65
- Custodial Care .................................................. 41, 65

### D

- Day Treatment Patient .................................................. 66
- Deductible .................................................. 66
- Definitions .................................................. 66
- Dental Procedures .................................................. 64
- Dental Service .................................................. 21
- Dental Services .................................................. 21, 41
- Department of Veterans Affairs .................................................. 41
- Dependent .................................................. 66
- Diabetic Services .................................................. 21
- Diagnostic Service .................................................. 66
- Diagnostic Services .................................................. 21
<table>
<thead>
<tr>
<th>Refractive Eye Surgery</th>
<th>37, 74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconstructive Procedures</td>
<td>74</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>43</td>
</tr>
<tr>
<td>Qualified Medical Child Support Order</td>
<td>4</td>
</tr>
<tr>
<td>Qualified Medical Child Support Order</td>
<td>5</td>
</tr>
<tr>
<td>Provider</td>
<td>71</td>
</tr>
<tr>
<td>Procedure for Appeal of Medical Necessity</td>
<td>42, 71</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>42</td>
</tr>
<tr>
<td>Medicaid</td>
<td>71</td>
</tr>
<tr>
<td>Medical Care</td>
<td>24</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>25</td>
</tr>
<tr>
<td>Medically Necessary Health Care</td>
<td>71</td>
</tr>
<tr>
<td>Medically Unnecessary Services</td>
<td>42</td>
</tr>
<tr>
<td>Medicare</td>
<td>43, 71</td>
</tr>
<tr>
<td>Member</td>
<td>71</td>
</tr>
<tr>
<td>Membership Additions</td>
<td>4</td>
</tr>
<tr>
<td>Mental Health</td>
<td>14, 43</td>
</tr>
<tr>
<td>Miscellaneous Expenses</td>
<td>43</td>
</tr>
<tr>
<td>Missed Appointments</td>
<td>43</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>26, 72</td>
</tr>
<tr>
<td>Network Provider or Professional Unavailable</td>
<td>15</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>49</td>
</tr>
<tr>
<td>Non-Transfer of Benefits</td>
<td>49</td>
</tr>
<tr>
<td>Obstetrical Services and Newborn Care</td>
<td>26</td>
</tr>
<tr>
<td>Office Visits</td>
<td>26</td>
</tr>
<tr>
<td>Organ and Tissue Transplants</td>
<td>27</td>
</tr>
<tr>
<td>Orthognathic Surgery</td>
<td>72</td>
</tr>
<tr>
<td>Orthotic Device</td>
<td>72</td>
</tr>
<tr>
<td>Orthotic Devices</td>
<td>28, 43</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>64</td>
</tr>
<tr>
<td>Out-of-Pocket Limits</td>
<td>48</td>
</tr>
<tr>
<td>Outpatient</td>
<td>72</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>28</td>
</tr>
<tr>
<td>Parenteral and Enteral Therapy</td>
<td>29</td>
</tr>
<tr>
<td>Payment for Prescription Drug Claims</td>
<td>55</td>
</tr>
<tr>
<td>Payments</td>
<td>46</td>
</tr>
<tr>
<td>Personal Comfort Items</td>
<td>43</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>72</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>29, 43</td>
</tr>
<tr>
<td>Plan</td>
<td>73</td>
</tr>
<tr>
<td>Plan Administrator</td>
<td>73</td>
</tr>
<tr>
<td>Plan Participant</td>
<td>73</td>
</tr>
<tr>
<td>Post-Admission Review</td>
<td>13</td>
</tr>
<tr>
<td>Pre-Admission Review</td>
<td>12</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>73</td>
</tr>
<tr>
<td>Preventive and Well-Care Services</td>
<td>36</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>12</td>
</tr>
<tr>
<td>Procedure for Appeal of Medical Necessity</td>
<td>12</td>
</tr>
<tr>
<td>Prostheses</td>
<td>22, 73</td>
</tr>
<tr>
<td>Provider</td>
<td>73</td>
</tr>
<tr>
<td>Marriage</td>
<td>4</td>
</tr>
<tr>
<td>Medicaid</td>
<td>71</td>
</tr>
<tr>
<td>Medical Care</td>
<td>24</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>25</td>
</tr>
<tr>
<td>Medically Necessary Health Care</td>
<td>71</td>
</tr>
<tr>
<td>Medically Unnecessary Services</td>
<td>42</td>
</tr>
<tr>
<td>Medicare</td>
<td>43, 71</td>
</tr>
<tr>
<td>Member</td>
<td>71</td>
</tr>
<tr>
<td>Membership Additions</td>
<td>4</td>
</tr>
<tr>
<td>Mental Health</td>
<td>14, 43</td>
</tr>
<tr>
<td>Miscellaneous Expenses</td>
<td>43</td>
</tr>
<tr>
<td>Missed Appointments</td>
<td>43</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>26, 72</td>
</tr>
</tbody>
</table>