University of Maine System

2019-2020 Student Health Plan

Important notice

This is a brief description of your Student Health Plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you'd like more details about your coverage and costs, you can get the complete terms in the policy or plan document online at anthem.com. You'll be able to get a copy of the full Master Policy as soon as it's available.

Anthem | STUDENT ADVANTAGE

anthem.com

116387MEMENABS 06/19

Who is eligible for the plan

Who is eligible?

You are eligible if you are a:

- Full-time undergraduate student. Full-time undergraduate student is defined as 9 or more credit hours per semester.
- Full-time graduate student. Full-time graduate student is defined as 6 or more credit hours per semester.
- Domestic undergraduate or domestic graduate student taking less than the required number of credit hours who are enrolled in a program of study that has an insurance requirement.
- Registered international student as required by their respective Universities.

You are not eligible if you are a:

- Dependent of a student
- Student living outside of Maine enrolled in only online courses

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV)

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

Enrollment and waiver process

University of Maine students will be required to show proof of having health insurance as a condition of course enrollment with each new school year if they meet the following eligibility criteria:

- Undergraduate students taking 9 credits or more
- Graduate or Law students taking 6 credits or more
- All students enrolled in clinical course work
- **Please note:** Non-Maine residents taking only online courses, and Stonecoast MFA participants are not typically eligible and not automatically enrolled.

Students who want to take advantage of the SHIP and/or have no other insurance coverage should complete the online enrollment steps to confirm their insurance enrollment and to get access to their ID card and benefits on the effective date of the policy. The enrollment deadline is October 1, 2019.

To enroll online, log onto: https://umaine.myahpcare.com/enrollment

To request a waiver of the UMS SHIP, your health insurance must meet the following criteria:

- Your insurance plan must provide coverage for more than emergency care while in Maine
- Your coverage must remain in effect through the academic year

Who is eligible for the plan

To waive online, log onto: https://umaine.myahpcare.com/waiver

All enrollment or waiver selections must be made by the enrollment and waiver periods noted below:

- The Annual enrollment/waiver period is **06/20/2019 - 10/01/2019**.
- The Spring enrollment/waiver period is **12/01/2019 - 02/20/2020**.

Coverage period

Coverage under the Plan will become effective at 12:01 a.m. on the later of, but no sooner than:

- The Master Policy effective date;
- The beginning date of the term for which premium has been paid;

The below enrollments will be allowed a **30 day** grace period from the term start date to enroll whereby the effective date will be backdated a maximum of **30 days**. No policy shall ever start prior to the term start date:

- All hard-waiver and mandatory (insurance is required as a condition of enrollment on campus) insurance programs.
- All re-enrollments into the same exact policy if re-enrollment occurs within **30 days** of the prior policy termination date.

Coverage under the Plan terminates at 12:01 a.m. on the earlier of:

- Date the Master Policy terminates for all Insured Persons; or
- End of the period of coverage for which premium has been paid; or
- Date the Insured Person ceases to be eligible for the insurance; or
- Date the Insured Person enters military service.

COVERAGE IS **NOT** AUTOMATICALLY RENEWED. Eligible persons must re-enroll when coverage terminates to maintain coverage. No notification of plan expiration or renewal will be sent.

Refunds

Refund of premium will be considered only:

- If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed.
- For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

Coverage periods and rates

Coverage periods

Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the coverage start date indicated below, and will terminate at 11:59 PM on the coverage end date indicated.

Coverage period	Coverage start date	Coverage end date	Enrollment/ waiver deadline
Annual	08/1/2019	07/31/2020	10/01/2019
Spring/summer	01/01/2020	07/31/2020	02/20/2020

Rates

Undergraduates and graduates	Annual	Spring
Student	$2,157	$1,255

Emergency travel assistance

As a participant in the student health plan, you have access to the emergency travel services and benefits when you are traveling over 100 miles from home or outside your home country.

To ensure you have immediate access to assistance if you experience a travel related crisis, Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis.

To contact Academic Emergency Services from the U.S or Canada, call: **1-855-873-3555**.

To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by the collect number: **1-410-453-6354**.

Important contact information

Insurance Company

Anthem Blue Cross Life and Health Insurance Company

Claims & Coverage Questions

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 105370
Atlanta, GA 30348-5370
1-844-412-0890

Find a Doctor or Preferred Care Provider

BlueChoice PPO
1-844-412-0890
Online Provider Finder

General information on Benefits, Eligibility & Enrollment

Academic HealthPlans
1-855-343-8389
https://umaine.myahpcare.com/

Servicing Broker

Cross Benefit Solutions
1-800-537-6444
www.crossagency.com/ums

Getting started

StudentHealth App

With the StudentHealth app through Anthem Student Advantage, you have instant access to:

- Your member ID card
- Find a Doctor
- More information about your plan benefits
- Health tips that are tailored to you
- LiveHealth Online and 24/7 NurseLine
- Student support specialists; just click to call or chat
- And more!

From your mobile device or tablet go to The App Store℠ or Google Play™ and search for the StudentHealth app to download it today.

LiveHealth Online

Using LiveHealth Online, you can visit with a board-certified doctor, psychiatrist or licensed therapist through live video on your smartphone, tablet or computer with a webcam. It's an easy and convenient way to get the care you need. Go to your StudentHeath app, livehealthonline.com or download the free LiveHealth Online app to sign up on your smartphone or tablet.

24/7 NurseLine

With 24/7 NurseLine , you can call registered nurses to help you with needs such as your fever, allergy relief tips and where to go for care. They can also help you enroll in valuable health management programs for certain health conditions, remind you about scheduling important screenings and exams, and more. Just call 844-545-1429 to speak to a registered nurse today.

Your choice

When you choose preferred providers

You get the highest level of benefits under your health care plan when you use services from preferred providers — which are doctors and hospitals in your plan. They're also called "in-network" providers and when you use them, you're using "in-network" benefits, which give you the best value for your plan. See the charts on the following pages for your share of the cost.

How to find a preferred provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of the directory, call Member Services at the number on your ID card.
- Visit Online Provider Finder

When you choose non-preferred providers

You can also receive covered services from non-preferred providers, which are doctors and hospitals not in your plan. But you pay more out-of-pocket because the benefits are "out-of-network." See the charts on the following pages for your share of the cost.

Note: If a preferred provider refers you for covered services to other providers, such as labs or specialists, make sure they're preferred providers so you can get in-network benefits, which give you the best value. If you use a non-preferred provider, you pay more out-of-pocket because your benefits are out-of-network even if a preferred provider refers you.

Your out-of-pocket maximum

Your out-of-pocket maximum is the most you could pay during a plan year for copays and coinsurance for covered services. See the charts on the following pages for more details.

Emergency room (ER) services

In an emergency, such as a suspected heart attack, stroke or poisoning, you should go directly to the nearest ER or call 911 (or the local emergency phone number). You pay a copay per visit for in-network or out-of-network ER services. See the charts on the following pages for your share of the cost.

Utilization review requirements

Utilization review is a process of looking at certain types of care, such as hospital admissions, to make sure they're needed, appropriate and efficient. You must follow the requirements of utilization review, including pre-admission review, pre-service approval for certain outpatient services, concurrent review and discharge planning, and individual case management. For more information about utilization review, see your plan document. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for preapproval.

Pediatric, Vision and Dental benefits

Your medical plan includes a vision and dental policy that covers pediatric essential benefits, for members until the end of the month in which they turn 19.

LiveHealth Online

LiveHealth Online lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student Health Plan: University of Maine System

Your Network: BlueChoice PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Student Health Center Benefits: The deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred after a $10 Copay per visit when treatment is rendered at the University of Southern Maine and the University of Maine at Farmington Student Health Center. The Deductible will be waived and benefits will be paid at 100% of the approved fee schedule after a $10 Copay per visit when treatment is rendered at the University of Maine Counseling Center. The Deductible will be waived and benefits will be paid at 100% of the approved fee schedule when treatment is rendered at the University of Maine at Presque Isle and The University of Maine at Machias Student Health Center.

Exceptions:

- *Emergency Room or Urgent Care*
- *Services outside the country*
- *Certain women's health services including pregnancy and maternity care*
- *Certain preventative and well visit services*

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Overall deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$400 per person	$400 per person
Out-of-pocket limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out-of-pocket maximum.*	$7,900 per person	$15,800 per person
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	20% coinsurance deductible does not apply

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Doctor home and office services:		
Primary care visit to treat an injury or illness	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist care visit	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Prenatal and post-natal care – maternity *In-Network preventive prenatal services are covered in full.*	Same as any covered sickness	40% coinsurance
Other practitioner visits:		
Retail health clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line medical visit *Live Health Online is the preferred telehealth solutions*	$30 copay per visit deductible does not apply	$30 copay per visit deductible does not apply
Chiropractic services *Coverage is limited to 40 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other services in an office:		
Allergy testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/radiation therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription drugs *For the drug itself dispensed in the office through infusion/injection*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic service:		
Lab		
Office *Office cost share applies only when Freestanding/Reference Labs are not used.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
X-ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding radiology center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and urgent care		
Walk in center (office visit charge)	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Emergency room facility services *Copay is waived if admitted.*	20% coinsurance after deductible is met, after $200 copay	Covered as In-Network
Emergency room doctor and other services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance transportation	20% coinsurance after deductible is met	Covered as In-Network
Outpatient mental/behavioral health and substance abuse		
Doctor office visit and online visit	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Facility visit		
Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor services	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Outpatient surgery		
Facility fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding surgical center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital stay (all inpatient stays including maternity, mental/behavioral health, and substance abuse)		
Facility fees (for example, room and board) *Coverage for Inpatient rehabilitation and skilled nursing services combined is limited to 150 days per benefit period. Limit is combined In-Network and Out-of-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery and Rehabilitation		
Home health care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient hospital *Coverage for physical therapy and occupational therapy combined is limited to 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient hospital *Coverage for physical therapy and occupational therapy combined is limited to 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 40 visits per episode. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient hospital *Coverage is limited to 40 visits per episode. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per year. Limit is combined In-Network and Out-of-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment *Coverage for hearing aids services is limited to 1 unit every 36 months per ear through age of 18. Limit is combine In-Network and Out-of-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Gender Reassignment Treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is rendered	Covered according to the type of benefit and the place where the service is rendered
Impacted wisdom teeth	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	In-Network Coverage	Out-of-Network Coverage
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket	Combined with medical out-of-pocket maximum	Combined with medical out-of-pocket maximum
Prescription Drug Coverage *Select Drug List*		
Tier 1 - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy).*	$15 copay per Prescription deductible does not apply (retail only).	40% coinsurance
Tier 2 - Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy).*	$45 copay per Prescription deductible does not apply (retail only).	40% coinsurance
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy).*	$75 copay per Prescription deductible does not apply (retail only).	40% coinsurance
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy).*	$75 copay per Prescription deductible does not apply (retail only).	40% coinsurance

Your summary of benefits

Covered Vision Benefits	In-Network Coverage	Out-of-Network Coverage
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Children's Vision Essential Health Benefits (up to age 19)		
Child vision deductible	$0 person	Not applicable
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	No charge	Reimbursed up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed up to $45
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 reimbursement for Single, $40 reimbursement for bifocal, and $55 reimbursement for Trifocal Vision Lens
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed up to $60
Non-elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed up to $210
Adult vision (age 19 and older)		
Adult vision deductible *Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.*	$0 person	$0 person
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed up to $30
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-elective contact lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	In-Network Coverage	Out-of-Network Coverage
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits		
Diagnostic and preventive *Coverage for In-Network Providers and Out-of-Network Providers is limited to 2 visits per 12 months.*	100% coinsurance	100% coinsurance
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically necessary orthodontia services	50% coinsurance	50% coinsurance
Cosmetic orthodontia services	Not covered	Not covered
Deductible	No deductible applies	No deductible applies
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Exclusions

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

Charges you pay for non-Covered Services do not count toward any Deductible, Coinsurance, or out-of pocket limits.

1. **Acts of War, Disasters, or Nuclear Accidents**
   In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, or riot.

2. **Administrative Charges**
   Charges to complete claim forms, charges to get medical records or reports, membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3. **Alternative/Complementary Medicine** services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   - Acupuncture
   - Holistic medicine
   - Homeopathic medicine
   - Hypnosis
   - Aroma therapy
   - Reiki therapy
   - Herbal, vitamin or dietary products or therapies
   - Naturopathy
   - Thermography
   - Orthomolecular therapy
   - Contact reflex analysis
   - Bioenergial synchronization technique (BEST)
   - Iridology-study of the iris
   - Neurofeedback/biofeedback

4. **Applied Behavioral Treatment**
   Including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.

5. **Before Effective Date or After Termination Date**
   Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

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

6. **Certain Providers**
   Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

7. **Charges Over the Maximum Allowed Amount**
   Charges over the Maximum Allowed Amount for Covered Services.

8. **Charges Not Supported by Medical Records**
   Charges for services not described in your medical records.

9. **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.

10. **Complications of/or Services Related to Non-Covered Services**
    Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

11. **Compound Drugs**
    Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, 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.

12. **Cosmetic Services**
    Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.

13. **Court Ordered Testing**
    Court ordered testing or care unless Medically Necessary.

14. **Crime**
    Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

15. **Custodial Care**
    Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

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

17. **Dental Services**
    Coverage is not provided for the following Dental-related services:

    - Dental care for members age 19 and older, unless covered by the medical benefits of this policy.
    - Dental services or health care services not specifically covered under the [policy] (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
    - Services of anesthesiologist, unless required by law.
    - Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
    - Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
    - Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    - Case presentations, office visits, consultations.
    - Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
    - Enamel microabrasion and odontoplasty.
    - Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the [policy].
    - Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this [policy].
    - Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this [policy].
    - Separate services billed when they are an inherent component of another covered service.
    - Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
    - Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
    - Provisional splinting temporary procedures or interim stabilization.
    - Pulp vitality tests
    - Adjunctive diagnostic tests
    - Incomplete root canals
    - Cone beam images
    - Anatomical crown exposure
    - Temporary anchorage devices
    - Sinus augmentation

- Oral hygiene instructions.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the effective date of this [policy] or received after the coverage under this [policy] has ended.
- Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this policy.
- Athletic mouth guards.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.

18. **Dental Treatment**
For injuries that are a result of biting or chewing, unless the chewing or biting results from a medical or mental condition. This Exclusion does not apply to services that we must cover by law.

19. **Drugs 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.

20. **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 based on FDA labeling.

21. **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.

22. **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 injectable insulin.) This exclusion does not apply to over-the-counter drugs that we must cover under Federal law when recommended by the U.S. Preventive Services Task Force and are prescribed by a physician (contraceptives). For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org.

23. **Drugs Prescribed by Providers Lacking Qualifications/Certifications Prescription**
Drugs prescribed by a Provider that does not have the necessary qualifications including certifications, as determined by Anthem.

24. **Educational Services**
Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

25. **Experimental or Investigational Services**
Services or supplies that we find are Experimental/Investigational. This also applies to services related to Experimental/Investigational services, whether you get them before, during, or after you get the Experimental/Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental/Investigational.

26. **Eyeglasses and Contact Lenses**
Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

27. **Eye Exercises**
Orthoptics and vision therapy.

28. **Eye Surgery**
Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

29. **Family Members**
Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

30. **Foot Care**
Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

- Cleaning and soaking the feet.
- Applying skin creams to care for skin tone.
- Other services that are given when there is not an illness, injury or symptom involving the foot.

31. **Foot Orthotics**
Orthotic devices unless stated as covered in the "What's Covered" section of this certificate.

32. **Foot Surgery**
Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

33. **Free Care**
Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

34. **Hearing Aids**
Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

35. **Health Club Memberships and Fitness**
Services Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

36. **Home Care**
    - Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    - Private duty nursing.
    - Food, housing, homemaker services and home delivered meals.

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

38. **Maintenance Therapy**
Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.

39. **Medical Equipment, Devices and Supplies**
    - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    - Non-Medically Necessary enhancements to standard equipment and devices.
    - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

40. **Medicare**
For which benefits are payable under Medicare Parts A, and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out-of-pocket costs.

41. **Missed or Cancelled Appointments**
Charges for missed or cancelled appointments.

42. **Non-Medically Necessary Services**
Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

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

44. **Nutritional or Dietary Supplements**
Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

45. **Off Label use**
Off label use, unless we must cover it by law or if we, or the PBM, approve it. Prescription drugs approved by the Federal Drug Administration (FDB) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.

46. **Oral Surgery**
Extraction of teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

47. **Personal Care and Convenience**
    - Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs
    - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads)
    - Home workout or therapy equipment, including treadmills and home gyms
    - Pools, whirlpools, spas, or hydrotherapy equipment
    - Hypo-allergenic pillows, mattresses, or waterbeds
    - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails)

48. **Private Duty Nursing**
Private Duty Nursing Services, unless listed as covered in this Booklet. Your coverage does not include benefits for private duty nursing in the inpatient setting.

49. **Prosthetics**
Prosthetics for sports or cosmetic purposes.

50. **Residential Accommodations**
Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
    - Domiciliary 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.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
    - Wilderness camps.

51. **Routine Physicals and Immunizations**
Physical exams and Immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the "Preventive Care" benefit.

52. **Sanctioned or Excluded Providers**
 Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services office of Inspector General List of Excluded Individuals/Etities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

53. **Sexual Dysfunction**
 Services or supplies for male or female sexual problems.

54. **Sterilization**
 Services to reverse an elective sterilization.

55. **Surrogate Mother Services**
 Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

56. **Temporomandibular Joint Treatment**
 Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

57. **Travel Costs**
 Mileage, lodging, meals, and other Member-related travel costs.

58. **Vein Treatment**
 Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

59. **Vision Services**
 Coverage is not provided for services incurred for or in connection with any of the items below:

 - Eyeglasses lenses, frames or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.
 - For safety glasses and accompanying frames.
 - For two pairs of glasses in lieu of bifocals.
 - For plano lenses (lenses that have no refractive power).
 - Lost or broken lenses or frames, unless the member has reached their normal interval for service when seeking replacements.
 - For services or supplies not specifically listed as covered in this Booklet.
 - Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
 - For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
 - Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
 - Blended lenses.
 - Oversize lenses.
 - For sunglasses.

60. **Waived Cost-Shares Out-of-network**
    For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

61. **Weight Loss Programs**
    Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

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

62. **Workers' Compensation**
    Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

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

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

    Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan.

Exclusions

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, 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. **Charges Not Supported by Medical Records**
   Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

3. **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.

4. **Compound Drugs**
   Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, 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.

5. **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.

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

7. **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 **"Prescription Drugs Administered by a Medical Provider"** section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.

8. **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. 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.

9. **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.

10. **Drugs Over Quantity or Age Limits**
    Drugs which are over any quantity limits set by the Plan or which are over any age limits based on FDA labeling.

11. **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.

12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications**
    Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.

13. **Family Members**
    Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

14. **Gene Therapy**
    Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

15. **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.

16. **Items Covered Under the Allergy Services"**
    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.

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

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

19. **Non-Medically Necessary Services**
    Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

20. **Nutritional or Dietary Supplements**
    Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

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

    Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.

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

23. **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 may not be covered, even if written as a Prescription. 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. For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org

24. **Sanctioned or Excluded Providers**
    Any Drug, Drug regiment, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.

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

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

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the Maine Department of Insurance.
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and Maine laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual out-of-pocket maximums include deductible, copays, coinsurance and prescription drug.
- In network and out-of-network deductible and out-of-pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (for example, X-ray, lab, surgery), after any applicable deductible.
- Preventive care services include physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out-of-network benefit and you use a out-of-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out-of-pocket maximum.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library

Your summary of benefits

- Additional visits may be authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out-of-network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Skilled nursing facility day limit does not apply to mental health and substance abuse.
- Respite care limited to five consecutive days per admission.
- Freestanding lab and radiology center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- Supply limits for certain drugs may be different; go to Anthem's website or call Customer Service.
- Certain drugs require preauthorization approval to obtain coverage.
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-330-1098.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。
(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오.
(TTY/TDD: 711)

Navajo

Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Get help in your language

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਚਿ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵੱਚਿ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਸਿਜ਼ਿ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en
su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

May karapatan kayong makakuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ.
(TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Questions: 1-855- 330-1098 or visit us at www.anthem.com