National EPO Option
Summary of Coverage for Eligible New York and New England Associates

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Introduction to Your Medical Coverage

This summary of coverage (SOC) document describes medical benefits under the Exclusive Provider Organization (EPO) option. It is part of your summary plan description (SPD), which provides additional Verizon medical plan information, including that required by the Employee Retirement Income Security Act of 1974 (ERISA).

Important Note: The EPO is not available to new enrollees. If you are enrolled in the EPO option as of October 19, 2012, you will continue to be eligible for coverage under the EPO option provided that you remain continuously eligible for the Alternate Choice Plan and enrolled in the EPO option. If you change medical options and are no longer enrolled in the EPO option, you will no longer be eligible to re-enroll in the EPO option.

If you have questions, call Anthem. The number is on your medical ID card.

This option is self-funded by Verizon Communications Inc. and administered by Anthem, the outside administrative organization. The benefits described in this SOC are effective as of January 1, 2013.

Accessing Your Benefits Information

Your medical benefits (including prescription drug coverage) are described in the following documents:

- This **EPO SOC**.
- The **medical SPD**.

Your medical SPD and the SOC for your medical option are available online on the BenefitsConnection website. Generally, the documents on the BenefitsConnection website are the most up to date. Once you have logged on to BenefitsConnection, select the "Summary Plan Descriptions" link on the Library page.

For free printed copies of your SPD or SOC, contact the Verizon Benefits Center at 1-855-4VzBens (1-855-489-2367).

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Participating Providers

You can request a list of participating providers, free of charge, by:

- Accessing Anthem's or Express Scripts' website.
- Accessing the BenefitsConnection website.
- Calling Anthem or Express Scripts directly.

See the "Medical plan contacts" information that follows.

Medical Plan Contacts

Option	Contact	Reasons to access
Exclusive Provider Organization (EPO) option		
For medical/ mental health and substance abuse treatment	Anthem www.anthem.com/verizon (User ID and password required) **Member Services** 1-855-869-8139 **Mailing address:** Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	• Request coverage information and order an ID card. • Locate a participating provider. • Request a provider directory, free of charge. • Submit claims and appeals, if necessary. • Check on the status of a claim. • Avoid penalties if you need surgery, hospitalization or certain other procedures. • Call if a covered individual is pregnant. • Avoid penalties if you have an emergency. • Pre-certify care if necessary, before you receive certain treatment. • Speak to a NurseLine℠ registered nurse. • Obtain referrals to appropriate services and providers. • Self-refer to the BlueCare Consultant program.
For prescription program	Express Scripts www.express-scripts.com/verizon **Member Services** 1-877-877-1878 (inside the U.S.) 1-972-915-6695 (outside the U.S.) **Mailing address** if you use a nonparticipating pharmacy: Express Scripts P.O. Box 14711 Lexington, KY 40512	• Talk to a pharmacist. • Renew and track a prescription. • Fill or refill a prescription. • Learn about potential savings on your prescriptions. • Check on the status of pending orders. • Request a mail-order form. • Price a medication. Pay your balance.

Other sources for information		
BenefitsConnection website Verizon Benefits Center	Via the Internet at: www.verizon.com/benefitsconnection (User ID and password required) Via About You on VzWeb 1-855-4VzBens(1-855-489-2367) Representatives are available from 8 a.m. to 6 p.m. Eastern time, Monday through Friday	• Enroll for coverage. • Verify overall eligibility and coverage. • Review personal benefits information. • Make changes to your coverage due to a qualified change in status. • Update dependent information. • Hotlink to medical option provider sites (online only). • Create and print personalized provider listings and maps to a physician's office (online only). • Verify eligibility for COBRA coverage. • Enroll for COBRA coverage. • Notify Verizon of a COBRA qualifying event. • Update COBRA coverage due to a subsequent COBRA qualifying event.
Subrogation vendor	Healthcare Recoveries Attention: Verizon Subrogation Unit P.O. Box 32200 Louisville, KY 40232 1-800-395-5568	• Request information about subrogation.

How the EPO Option Works

The Exclusive Provider Organization (EPO) option uses the Anthem BlueCard PPO network. You must use a network provider to receive benefits. Check with your provider to be sure he or she participates in the network before you make your appointment. When you use network providers, benefits are based on network negotiated fees (NNF).

The EPO option covers health services, with no deductible, annual out-of-pocket maximum or lifetime maximum benefit. Under the EPO option, you pay a copay for office visits and outpatient laboratory and X-ray services. You also pay an inpatient hospital admission copay each time you are admitted to the hospital.

Using the EPO Network

An EPO is a network of health care providers who agree to charge a network negotiated fee (NNF) for certain services. The NNF is the maximum amount a network provider can charge for these services. See the "Accessing Your Benefits Information" section to get a list of providers.

When you use an EPO provider, you must show your ID card to receive the network negotiated fee charge.

In general, there are no claim forms to fill out when you use an EPO participating provider. If you do not use a participating provider, generally your expenses are not covered with the exception of certain emergency situations. In this case, you will need to complete a claim form. See the "Filing claims" section for additional information.

Covered Services

The EPO option pays benefits for medically necessary services and supplies, when provided or ordered by a hospital, doctor or physician to diagnose or treat an illness or injury.

In addition, to be covered, a service or supply must:

- Be recognized throughout the doctor or physician's profession as safe, appropriate, effective and essential.
- Be used appropriately in a manner and setting consistent with generally accepted U.S. medical standards.
- Be the most efficient and economical service or supply that safely can be provided.
- Not be educational or developmental or experimental or investigational in nature.
- Not be solely for the convenience of the patient, the family, or the provider.
- Not be primarily custodial.

Though a covered provider may have prescribed, recommended, or approved a service, supply or equipment, it does not in itself make it medically necessary.

In the case of a hospital stay, in addition to meeting the above tests, the length of the stay and hospital services and supplies must be considered medically necessary, as determined by Anthem.

A service or supply for treatment of a newborn is considered medically necessary if it is either of the following:

- For the medical care of a diagnosed illness, including a congenital defect or birth abnormality, or injury and meets all of the medical necessity tests outlined earlier.

- Provided immediately after the child's birth and is one of the following:

  — Hospital room and board.

  — Other hospital supplies and nonprofessional services furnished to newborns.

This definition is used only to determine the EPO's benefits and not for determining what type of medical care should be provided. All decisions related to the type of medical care to be provided are made independently by you and your physician.

Inpatient Hospital Admission Copay

Each covered person pays a copay of $150 each time he or she is admitted to the hospital. A separate copay is required for each hospital admission.

Get Well, Stay Well, Be Well – Your Health Management Resources

Anthem health management resources provide personal attention, convenience, education and guidance for a healthier you. Whatever your health needs, goals or concerns, you are not alone, but you are unique. The service is unique too as it is specially designed to serve all of your and your family's needs, not just a specific problem. Anthem's BlueCare Consultant program offers access to a specialized team that includes nurses, pharmacists, dieticians, social workers and behavioral health specialists – to help you navigate your health care to Get Well, Stay Well, and Be Well.

- BlueCare Consultant program
  - —ConditionCare (disease management)
  - —MyHealth Notes (member communication)
  - —Behavioral health support
  - —Future Moms (maternity support)
  - — 24/7 NurseLine
- Other tools and resources

The information and assistance these programs offer is not a substitute for your physician's medical judgment. It is, however, a great resource that will help you and your doctor make informed decisions about your health. You and your physician must decide what medical care you or your dependents receive.

BlueCare Consultant Program

The BlueCare Consultant program encourages an efficient system of care for you and your covered dependents by identifying and addressing possible unmet covered health care needs.

A BlueCare Consultant nurse may provide the following services:

- Inpatient care advocacy – If you are hospitalized, a BlueCare Consultant works with your physician to make sure you are getting the care you need and that your physician's treatment plan is being carried out effectively.
- Readmission management – This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted.

- Risk management – If you have certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information and coordination of equipment and supplies.

- Cancer Support – Anthem's BlueCare Consultant program is available to you to provide oncology support, education and care coordination. You will have access to registered nurses and the support of social workers, pharmacists, dietitians, behavioral health specialists and exercise physiologists.

A BlueCare Consultant also reviews your medical information (for example, medical and pharmacy claims) and may reach out to you to offer educational information, tips, advice or suggestions on a health-related issue based on your health profile. If you do not receive a call from a BlueCare Consultant, but feel you could benefit from the program, you can call in at any time.

You, your representative or your doctor must call your BlueCare Consultant through Member Services regarding the services outlined below and within the time frames specified below. If you do not call your BlueCare Consultant when required, your claim may be denied as not covered.

- Hospitalization – when possible, at least five days before a regular inpatient admission.

- Emergency care – within two business days or as soon as practicable following situations that require inpatient admissions.

- All organ or tissue transplants – when possible, at least 15 days before the scheduled date of an evaluation, donor search, organ procurement/tissue harvest or transplant.

- Skilled nursing facility/home health care/hospice care/private duty nursing/rehabilitation facility admissions/home infusion therapy – before any admission to a skilled nursing facility or before receiving any home health care or hospice services.

- Pregnancy – if the mother's hospital stay needs to be extended beyond 48 hours for a normal birth or 96 hours for a cesarean section, call within the 48- or 96-hour period, respectively.

- High-risk pregnancy – if there is a high risk of premature delivery, or a condition that would be harmful to the mother or the fetus, notify your BlueCare Consultant so that special attention can be provided. Additionally, contact your BlueCare Consultant if a high-risk condition develops at any time during the pregnancy.

- Newborn stay beyond the mother's stay – if the newborn needs to stay in the hospital longer than the mother.

- Orthognathic surgery (surgery to correct facial skeleton abnormalities) – when possible, at least 15 days before the procedure is performed.

- Durable medical equipment – when possible, at least 15 days before purchasing or renting durable medical equipment when the cost is more than $5,000.

- Bariatric procedures (surgeries to correct morbid obesity) performed in an inpatient and outpatient setting – when possible, at least 15 days before the procedure is performed.

- Plastic/reconstructive surgeries including but not limited to blepharoplasty, rhinoplasty, panniculectomy and lipectomy/diastasis recti repair, insertion/injection of prosthetic material collagen implants and chin implant/mentoplasty/osteoplasty mandible – when possible, at least 15 days before the procedure is performed.

- Uvulopalatopharyngoplasty (UPPP) surgery.

- Inpatient behavioral health and substance abuse treatment and electroconvulsive therapy.

- Air ambulance or non-emergency ambulance transport.

Pre-Certification

To receive benefits, you, a family member or your physician must contact your BlueCare Consultant to pre-certify the following:

- Bariatric procedures.

- Elective admissions.

- Emergency admissions (no later than two days after the admission).

- OB-related admissions (complications, excludes childbirth).

- Use of a freestanding birthing center.

- Newborn hospital stays beyond the stay of the mother.

- Inpatient hospitalization.

- Rehabilitation admissions.

- Confinement in a skilled nursing facility.

- Home health care.

- Hospice care.

- Private duty nursing.

- Certain outpatient procedures, services and tests, as determined by Anthem.

- All inpatient mental health and substance abuse treatment.

- Outpatient ECT, psychological testing, neuropsychological testing, amytal interview and hypnosis.

- Elective, rehabilitation and long-term acute care facility admissions.

- All organ and bone marrow/stem cell transplants.

- Nonemergency ambulance or ambulette transport.

- Lumbar spinal injuries.

Your BlueCare Consultant will notify you and your physician of Anthem's decision. If you or your physician disagrees with Anthem's decision, you can appeal the decision.

You must certify emergency hospital admissions no more than 48 hours after admission or the next business day, whichever is later.

Outpatient Procedures Requiring Pre-Certification

The following require pre-certification before the procedure or treatment is performed. Even though these procedures or treatments are most often done on an outpatient basis, pre-certification is required whether the procedure or treatment will be performed on an inpatient or outpatient basis:

- Plastic/reconstructive surgeries.

- Bariatric procedures.

- Bone marrow and stem cell transplants.

- Private duty nursing (home).

- Uvulopalatopharyngoplasty (UPPP) surgery.

- Home infusion therapy.

- Hospice care.

Pre-Certification Requirements

All admissions to hospitals or health care facilities, including inpatient hospital stays (including inpatient mental health and substance abuse treatment), hospice care, and stays in a skilled nursing facility, should be pre-certified by the claims administrator. The claims administrator will review the case and determine whether the proposed service or supply will be covered as medically necessary under the Plan. (No benefits will be paid for services and supplies found to be not medically necessary.) The claims administrator then will notify the physician and the covered person of its decision. If you or your physician disagrees with the claims administrator's decision, you can appeal the decision. (See the "Additional Information" section for more information.)

Reimbursement Rules With Pre-Certification

If you obtain pre-certification and the claims administrator determines that your service or supply is medically necessary, the Medical Plan will pay the regular level of benefits up to the number of days for inpatient treatment certified by the claims administrator.

Reimbursement Rules Without Pre-Certification

If you fail to receive proper pre-certification for a service that requires pre-certification, your claim(s) will be suspended to request medical records. If the medical records are not received within 21 days, your claim will be denied and your care will not be covered by the Medical Plan. However, once the

medical record information is received, your claim can be re-opened and only medically necessary services will be paid.

Concurrent Review

Concurrent review is the review by the claims administrator of the covered person's condition while hospitalized to determine whether the inpatient confinement will continue to be covered as medically necessary. During an inpatient confinement, the claims administrator periodically will review the covered person's case and may modify the number of days of inpatient confinement initially authorized. If a covered person enrolled in the EPO option is hospitalized in a participating network hospital, no further action is required on that person's part. If a covered person is hospitalized in an out-of-network facility under the EPO option, generally, services are not covered (emergency exceptions apply as determined by the claims administrator).

If the covered person's physician disagrees with the claims administrator about whether additional days of inpatient hospitalization should be covered by the EPO option, the covered person or his or her physician may appeal the claims administrator's decision by providing additional information supporting the necessity of the additional days of hospitalization. (See the "Additional Information" section for information on claims and appeals.)

Medical decisions regarding length of stay beyond the number of days authorized and paid for under the terms of the Plan as medically necessary are between the patient and his or her doctor.

ConditionCare (Disease Management)

Anthem offers support for a wide variety of medical conditions. You may be eligible to participate if you have been diagnosed or are at-risk for any of the following conditions:

- Asthma.
- Chronic Obstructive Pulmonary Disorder (COPD).
- Congestive heart failure.
- Coronary artery disease.
- Diabetes.
- Depression.
- Low back pain.
- Musculoskeletal conditions.
- Vascular at risk (hyperlipidemia/hypertension).

Designed to provide guidance about your medical condition at no cost to you, this service includes educational information, health tips and access to a team of clinicians that includes professionals such as registered nurses and dieticians.

If you do not receive a call or information in the mail, but feel you could benefit from the program, call BlueCare Consultants through Member Services.

Blue Distinction Center

You or your covered dependents who need a high-risk procedure may elect to use one of the hospitals included in the Blue Distinction Center network established by the claims administrator. High-risk procedures include organ or bone marrow transplants and other procedures, as determined by the claims administrator. Plan benefits for the hospitalization and transplant procedure shall be determined in the same way, regardless of whether a Blue Distinction Center network facility is used for the transplant. In addition, when a transplant procedure is performed at a designated Blue Distinction Center network facility, the Plan will pay reasonable travel and accommodation expenses (up to $10,000) for the covered person and one companion. You can get in touch with a BlueCare Consultant by calling the Member Services phone number on the back of your ID card and ask to speak with a BlueCare Consultant.

MyHealth Notes (Member Communication)

Information can be an important tool for improving your health. As a part of your Anthem plan, technology is used to monitor your health information and look for improvement opportunities. The health information from Anthem is continuously reviewed and MyHealth Notes will come to you through your mail at home or at www.anthem.com when there are recommendations specific for you or an adult dependent. This includes reminders about preventive services and compliance with tests or medications that are necessary for a specific condition. If you receive MyHealth Notes and have a question, you can call in to the toll-free number that is included in the Note.

Behavioral Health Support

Behavioral health support provides a private, strictly confidential, toll-free telephone service available 24 hours a day, seven days a week that connects you or your family member to trained counselors and information on treatment benefits. Behavioral health support includes: answering your benefit and service questions, providing assistance with provider referrals, helping you prepare for therapy and providing care management programs for mental health and substance abuse conditions, such as depression or alcohol abuse.

Future Moms (Maternity Support)

Whether you are a first-time mom-to-be or just considering becoming pregnant, Anthem works with you to offer information and guidance through all stages of your pregnancy. By participating in the program, you are taking the first step in growing a health family. Over the course of your enrollment, a registered nurse will coordinate your care and collaborate with your physician as appropriate to your treatment plan. In those incidences when it is needed, special nurses – who are experienced with premature births or NICU (Neonatal Intensive Care) – will be available after you deliver.

24/7 NurseLine

Have you or a family member ever experienced medical symptoms, but you were not sure whether you needed to see a doctor or go to the emergency room? The 24/7 NurseLine may be able to help. Use the 24/7 NurseLine when:

- Someone in your family has a minor sickness or injury and you are not sure what to do first.

- You are traveling on business or vacation and need assistance with a medical question or concern.
- It is after hours and your physician is not available.
- You have a question about how to take prescription or over-the-counter medications safely.
- You are interested in other health or wellness information.

An audio health library is also available for times when you do not need to speak with a nurse, but are still looking for information. Recorded topics include:

- First aid.
- Infant/child health.
- Depression/anxiety.
- Quitting smoking.
- Prescription/over-the-counter medication.
- ADHD.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

Other Tools and Resources

You also have access to a wide variety of information and tools online. By using www.anthem.com/verizon you can perform many self-service functions at your convenience, day or night. You can:

- Learn more about general health topics.
- Participate in online health communities in a secure environment.

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What is Covered

The Exclusive Provider Organization (EPO) covers the following services, supplies and expenses. Anthem is an independent organization with its own contract provisions, benefits and network providers. If you have questions about covered charges, you should contact Anthem. See the "Medical plan contacts" section for contact information.

- Preventive care services.
- Physician services, X-rays and diagnostic laboratory tests.
- Hospitalization, inpatient surgery and outpatient surgery.
- Maternity care and family planning.
- Skilled nursing care, home health care and hospice care.
- Other services.
- Mental health and substance abuse treatment.

The remainder of this section provides more details about covered medical services. Mental health and substance abuse treatment is described in the next section.

Preventive Care Services

Option provision	**EPO pays when using network providers**
Well-baby care	**100%**
Routine preventive care/wellness visits to assess a baby's growth and development. Coverage includes office visits and associated lab work.	
General physical exam	**100%**
Tests and services normally associated with preventive care include, but are not limited to, the following, if ordered by your doctor:	
• Blood pressure. • Chest X-ray. • EKG. • 1 flu vaccine each calendar year. • Height and weight. • Hematocrit.	• Intradermal tuberculosis testing. • Lab tests (CBC and SMAC). • Lipid profile. • Serum cholesterol. • Urinalysis. • Venipuncture.
Well-woman exams Includes Pap test and related lab fees	**100%**

Option provision	EPO pays when using network providers
Mammograms	**100%**
Immunizations and flu shot	**100%**
Prostate-specific antigen test and digital rectal exam	**100%**
Colonoscopy (colon cancer test) and sigmoidoscopy	**100%**
Fecal occult blood test	**100%**
Routine radiology	**100%**
Bone density testing	**100%**

Physician Services, X-Rays and Diagnostic Laboratory Tests

Option provision	EPO pays when using network providers
Physician Visits, Including OB/GYN – Services for Diagnosis and Treatment of an Illness or Injury	**100%,** after $20 copay
Specialist visits	**100%,** after $25 copay
Allergy Testing	**100%**
Allergy Treatment – Serum/Injections	**100%**
Voluntary Second surgical Opinion	**100%,** after $20 PCP copay/ $25 specialist copay
X-rays and Diagnostic Laboratory Tests • Office visit • In an outpatient facility	**100%,** **100%**
Chiropractic Services Up to 20 visits per calendar year	**100%,** after $25 copay
Exclusions Any type of therapy, service or supply including, but not limited to, spinal manipulations by a physician, chiropractor or other health care professional for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	

Hospitalization, Inpatient Surgery and Outpatient Surgery

Option provision	EPO pays when using network providers
Hospitalization and inpatient surgery	
• Physician charges • Facility charges	**100%** **100%,** after $150 per admission copay

The EPO covers semiprivate room and board for a medically necessary hospital confinement, subject to pre-certification and concurrent review.

Hospital services and supplies include, but are not limited to:
- Anesthesia and its administration.
- Special diets.
- Intravenous solutions and injections.
- General nursing care (excluding care by private duty nurses).
- Services of radiologists and pathologists.
- Routine nursery care of an eligible newborn child while the mother is hospitalized for maternity care.
- Use of operating, delivery, recovery and treatment rooms and equipment.
- Sterile tray service.
- Recognized drugs and medicines provided by the hospital.
- Dressings, splints, casts and necessary supply items.
- Physical, speech, vocational and occupational therapy, if needed to restore a function that was lost due to illness or injury.

Exclusions
The EPO does not cover the following inpatient hospital services and supplies:
- Hospital inpatient care if the confinement is for dental treatment or services, except in the case of:
  - Dental treatment or services for accidental injury to sound, natural healthy teeth occurring while the individual is a covered person under the option.
  - Surgery for temporomandibular joint (TMJ) disorder, unless Anthem determines that the treatment is medically necessary.
  - Removal of impacted teeth if hospitalization is medically necessary, but only if a physician other than a dentist certifies that hospitalization is medically necessary.
  - Dental treatment or service when a physician other than a dentist certifies that hospitalization is medically necessary.
- Hospitalization that is primarily for physical therapy or speech therapy that could have been provided on an outpatient basis.
- Hospitalization that is primarily for X-rays, lab and other diagnostic studies.
- Hospital private room charges above the most prevalent semiprivate room rate of that hospital or hospitals in the area.

Option provision	EPO option pays when using network providers
Human organ and tissue transplants Your provider must pre-certify an organ transplant with your BlueCare Consultant for you to receive benefits. Transplants performed in non-Blue Distinction Center for Transplants (BDCT) facilities are covered at 100%.	**100%**
Human organ and tissue transplants are covered, subject to the following: • If the recipient and donor both are covered persons under the EPO, benefits are provided for both parties. • If the recipient is a covered person under the EPO, but the donor is not, benefits are provided for both individuals to the extent that benefits are not provided to the donor under any other plan. • If the donor is a covered person under the EPO, but the recipient is not, benefits are provided to the donor for his or her expenses only. No benefits are provided to the recipient. When a transplant procedure is performed at a designated BDCT facility, the EPO covers eligible charges for organ and tissue transplants at 100%. It also pays reasonable travel and accommodation expenses, subject to daily limits set by Anthem and not to exceed $10,000, for you and 1 companion (2 companions if the patient is a minor). A $50 per day lodging maximum applies. Your provider must pre-certify an organ transplant with your BlueCare Consultant for you to receive benefits.	
Outpatient surgery • Physician charges — In the office — In a facility	**100%,** after $20 copay for PCP/ $25 copay for specialist **100%**
Covered charges may include the services of an assistant surgeon when required by the surgical procedure and approved by Anthem. ***Multiple surgical procedures*** If your doctor performs 2 or more necessary surgical procedures through the same incision or operative field, the primary procedure is covered at regular rates. The EPO pays 50% of the regular benefit for the secondary procedure and 25% of the regular benefit for all other procedures. If multiple procedures are performed through different incisions during the same operation, the EPO pays regular benefits for each procedure.	
Emergency Care Emergency care is covered for treatment of injuries within 72 hours of an accident or treatment of a sudden, serious and life-threatening illness, as defined by Anthem.	**100%,** after $75 copay
Non-emergency use of emergency care facilities	**Not covered**
Urgent care Urgent care is covered for treatment of conditions or services provided that are nonpreventive or nonroutine and needed in order to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition, as defined by Anthem.	**100%,** after $25 copay
Non-urgent use of urgent care facilities	**100%,** after $25 copay

Maternity Care and Family Planning

Coverage is provided for the following charges related to a normal pregnancy:

Option provision	EPO option pays when using network providers
Doctor's office visits for prenatal care and the doctor's associated delivery services	**100%,** after $20 copay for initial visit
Facility charges	**100%,** after $150 copay
• Hospital charges for the mother and newborn for up to 48 hours after normal delivery or 96 hours after a cesarean section: — If the doctor determines the hospital stay for the mother and/or her newborn should be extended, you must contact your BlueCare Consultant to receive full benefits for the extended portion of the stay. — The doctor may discharge the mother or the newborn in less time than the legally required stays of 48 hours or 96 hours, but only after consulting with the mother. For more information, see "Your maternity rights (Newborns' and Mothers' Health Protection Act)" in "Your Medical Coverage" summary plan description (SPD). • Routine charges for the care of a newborn, including: — Hospital charges for nursery care, including room and board, services and supplies. — Doctor's charge for routine visits while the baby is in the hospital. — Surgeon's fees for circumcision. • Any non-routine services for the care of a newborn such as, services received through the Neonatal Intensive Care Unit (NICU) or stays that extend beyond the mother, may incur separate facility and physician charges.	
Birthing center Includes room and board, medical services and supplies and anesthetics and their administration	**100%,** after $150 copay
Nurse-midwife services	**100%**
Services of a nurse-midwife who is a licensed registered nurse (L.R.N.) and has completed a state-approved nurse-midwife preparation program	
Treatment for infertility	**100%**
Coverage includes: • Diagnosis and treatment of underlying cause. • Artificial insemination, limited to 6 courses of treatment per lifetime. Coverage does not include donor egg retrieval or advanced reproductive technology such as in vitro fertilization, GIFT, ZIFT, cryo-preserved embryo transfers or ovum microsurgery. (To be eligible for infertility benefits, contact your BlueCare Consultant before a procedure is performed.)	
Surgery for sterilization An initial voluntary sterilization procedure for a male or female is covered at 100% without a waiting period or doctor's approval. Reversals of voluntary sterilization procedures are not covered.	

Skilled Nursing Care, Home Health Care and Hospice Care

Option provision	EPO option pays when using network providers
Skilled nursing facility Up to 120 days per calendar year	**100%,** after a $150 copay

While you may not need the level of care provided in a hospital, you still may need 24-hour medical supervision.
As long as you remain under a doctor's care, the EPO covers care in a skilled nursing facility when medically necessary, including:

- Room and board, including general nursing services, meals and special diets.
- Use of special treatment rooms.
- Prescription drugs prescribed by the physician, but only if billed for and provided by the skilled nursing facility.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic services.
- Therapy services.
- Physicians' medical visits and consultations, up to 1 visit per day.

A skilled nursing facility is a facility that provides medically necessary continuous professional nursing supervision to covered persons who are not in the acute phase of illness but require primarily convalescent, rehabilitative and/or restorative services. The facility also may include intermediate, residential or long-term care units. Beds must be set up and staffed in a unit(s) specifically designated for this service.

The facility must meet all of the following requirements:

- Is licensed to provide, and provides, the following on an inpatient basis for covered persons convalescing from illness or injury: professional nursing care, 24 hours a day, by a registered nurse (R.N.) or by an L.P.N. directed by a full-time R.N.; and physical restoration services to help covered persons meet a goal of self-care in daily living activities.
- Is supervised full time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mentally retarded persons, for custodial care or educational or developmental care, or for care of mental disorders.
- Charges for its services.

Exclusions

- Physicians' medical visits in a skilled nursing facility in excess of 1 visit per day.
- Treatment of covered persons who have reached the maximum level of recovery possible for their particular condition and who no longer require definitive treatment other than routine supportive care.
- Treatment that is needed only to assist with the simple activities of daily living or to provide the protection of an institutional environment as a convenience to you.
- Custodial care that does not require medical or nursing services.
- Treatment of primary mental illness, including drug addiction, chronic brain syndrome and alcoholism without other specific medical conditions of a severity to require care. However, this exclusion does not apply to covered persons with primary illness receiving short-term convalescent care for a secondary medical condition for whom prognosis for recovery or improvement is considered favorable for that medical condition.
- Treatment of covered persons suffering senile deterioration who do not have a treatable medical condition requiring attention.
- Maternity care and care for newborns or infants.

Option provision	EPO option pays when using network providers
Private duty nursing is not covered except as described under “Home health care” and “Outpatient private duty nursing.” To be eligible for benefits, call your BlueCare Consultant before receiving home health care services.	
Home health care Up to 120 visits per calendar year Home IV therapy visits do not count towards the maximum.	**100%**
Sometimes a hospital stay can be shortened or avoided altogether if medical services can be provided at home. The EPO covers expenses: • For home health care treatment plans ordered and supervised by your doctor. • Provided by a home health care agency including: — Part-time or intermittent nursing care by or under the supervision of an R.N. or by a qualified home health aide. — Physical, occupational and speech therapy. A home health care agency must meet Anthem’s requirements, which include the following: • Is licensed in the state where it is located, if required. • Operates according to state laws. • Has a full-time administrator and its staff includes at least 1 physician and 1 R.N. Home health care benefits are calculated on a per-visit basis. 4 hours of care by a home health care aide are considered 1 visit and each visit by a nurse or therapist is considered 1 visit. To be eligible for benefits, call your BlueCare Consultant before receiving home health care services. ***Exclusions*** Services for custodial care, services of a social worker, transportation or any period that you are not under the care of a doctor.	
Outpatient private duty nursing (covered as part of home health care) Up to 120 visits per calendar year	**100%**
Part-time or intermittent nursing care by or under the supervision of an R.N. or by a qualified home health aide. Charges made by a R.N. or L.P.N. or a nursing agency for private duty nursing care. Private duty nursing by a R.N. or L.P.N. means that the person’s condition requires skilled nursing services and visiting nursing care is not adequate. Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	

Option provision	EPO option pays when using network providers
Exclusions • That part or all of any nursing care that does not require the education, training and technical skills of a R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs and companionship activities. • Any private duty nursing care given while the person is an inpatient in a hospital or other health care facility. • Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair or toileting. • Care provided solely for skilled observation except: — For no more than 1 4-hour period per day, for a period of no more than 10 consecutive days following the occurrence of any of these: – Change in patient medication. – Need for treatment of an emergency condition by a physician or the onset of symptoms indicating the likely need for such treatment. – Surgery. – Release from inpatient confinement. — Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by a R.N. or L.P.N. To be eligible for benefits, call your BlueCare Consultant before receiving home health care services.	
Hospice care	**100%**
Hospice programs provide care to meet the physical and psychological needs of terminally ill patients at home or at a facility where patients are cared for in a comfortable and supportive home-like environment. A patient is considered terminally ill if he or she has a life expectancy of less than 12 months. The purpose is to make the patient comfortable, rather than to attempt a cure. Often, hospitals set aside a floor or a wing as a hospice center. Hospice care must be provided through the EPO's hospice care program, which includes a written plan that includes an assessment of the patient's medical and social needs and a description of the care to be given. Before receiving hospice services, call your BlueCare Consultant to be sure you are eligible to receive benefits. The EPO covers the following hospice care services: • Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day. • Part-time or intermittent home health aide services for up to 8 hours a day. These consist mainly of caring for the person. • Services and supplies provided by a physician, dietician, social worker, respiratory therapist, physical therapist, speech therapist and occupational therapist. • Counseling services for the patient and his or her immediate family during the illness. • Medical supplies and prescribed drugs and medicines. • Semiprivate room and board and general nursing care on an inpatient basis. • An unlimited number of telephone counseling sessions for the patient and surviving covered family members while the patient is receiving hospice care, as well as 5 visits of bereavement counseling for your immediate family.	

Other Services

Option provision	EPO option pays when using network providers
Medical services and supplies	**100%**
The EPO pays for the following: • Medical and surgical supplies including bandages, dressings, orthopedic braces and crutches ordered by a doctor or physician. Contact your BlueCare Consultant if a durable medical equipment purchase will exceed $5,000. • Blood and blood derivatives that are not donated or otherwise replaced. • Oxygen and its administration, including the rental of required equipment.	
Physical therapy and occupational therapy Up to a combined maximum of 60 visits per calendar year for physical, occupational and speech therapy	**100%,** after $25 copay
Coverage is provided only for rehabilitation services that are expected to result in measurable, documented improvement in the patient's condition. The EPO covers up to a combined maximum of 60 visits during a calendar year for physical, occupational and speech therapy to a licensed physical or occupational therapist. ***Rehabilitation therapy*** Coverage is provided for inpatient or outpatient rehabilitation therapy that is necessary to improve the ability to function independently. Inpatient rehabilitation therapy includes room and board, care and treatment. Outpatient therapy includes the services of a hospital or comprehensive outpatient rehabilitative facility. ***Exclusions*** Any type of therapy, service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	
Speech therapy Up to a combined maximum of 60 visits per calendar year for physical, occupational and speech therapy	**100%,** after $25 copay
Speech therapy benefits are available only for rehabilitation services that are expected to result in measurable, documented, physical improvement in the condition. The options cover up to a combined maximum of 60 visits during a calendar year for physical, occupational and speech therapy, provided by a licensed speech therapist.	
Emergency ambulance service	**100%**
Coverage is provided for professional ground ambulance to and from a hospital or other medical facility for emergency services. Coverage is also provided for an air ambulance when medically necessary. Contact your BlueCare Consultant regarding requests for nonemergency ambulance service.	
Durable medical equipment	**100%**
Coverage is provided for the rental or purchase of durable medical equipment. If the cost of the purchase or rental is more than $5,000, you must contact your BlueCare Consultant for a determination as to what benefits are available. The claims administrator determines whether an item is eligible for rental or purchase, regardless of cost.	

Option provision	EPO option pays when using network providers
Deluxe wheelchairs are covered up to the allowance of the base model.	
Acupuncture services Up to 20 visits per calendar year	**100%,** after $25 copay
Anthem customarily covers acupuncture services in connection with surgery and in other medically necessary situations. Covered services include acupuncture use for: • Pain and nausea after surgery. • Low back pain. • Headaches/migraines. • Fibromyalgia. • Osteoarthritis. • Postoperative dental pain. • Relief of chronic menstrual cramps. The option covers up to a maximum of 20 visits during a calendar year for acupuncture treatment of pain and nausea by an M.D., D.O., D.C. or acupuncturist licensed by the state or certified by the National Commission of Acupuncturists/OMD. Additional services are covered if approved by the claims administrator.	
Radiation therapy	**100%,** after $25 copay
Chemotherapy	**100%,** after $25 copay
Reconstructive surgery	**100%**
Coverage is provided: • When considered medically necessary. Procedures are considered medically necessary if there is a significant functional impairment and the procedure can be reasonably expected to improve the physical functional impairment. • For breast reconstruction following a necessary mastectomy. For more information, see "Your rights following a mastectomy (Women's Health and Cancer Rights Act of 1998)" in "Your Medical Coverage" SPD. • For additional reconstruction purposes, when intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect. Contact your BlueCare Consultant before undergoing a reconstructive procedure to verify that the procedure is covered and not considered cosmetic in nature.	
Artificial limbs or eyes	**100%**
Artificial limbs or eyes and other appliances are covered for the replacement of a body organ or part. The EPO covers the first appliance only, unless a replacement is necessary because of growth and physical change. If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.	

Option provision	EPO option pays when using network providers
Oral surgery • Office visit • In a facility	**100%,** after $25 copay **100%**
Coverage is provided for: • Oral surgery performed for the treatment of non-dental diseases, injuries and defects of the mouth, the jaws and associated structures. • The excision of bone or tissue from other than the oral cavity as a donor site for purposes of grafting, in connection with dental surgery covered under the Verizon dental plan, as long as the grafting is necessary due to an accidental injury or illness. See "Your Dental Coverage" SPD for more information.. • Surgical treatments of TMJ disorder, as long as they are medically necessary. • Anesthesia in connection with covered oral surgery, as long as it is medically necessary. Expenses for oral surgery should be submitted to the Verizon dental plan first. If the Verizon dental plan does not cover all the charges, submit your claim to the Verizon medical plan for review.	
Treatment of TMJ dysfunction Coverage includes exams, X-rays, injections, anesthetics, physical therapy, oral surgery and supplies. • Office visit • In a facility ***Exclusions*** Tooth reconstruction or any treatment that is not medical in nature	**100%,** after $25 copay **100%**
Hearing aids and supplies	**100%**
Covered for dependents up to age 18 with hearing loss due to birth defect, illness, injury or accident. Not covered for progressive hearing loss. Includes hearing exams and hearing aid accessories.	
Vision services (non-routine)	**100%,** after $20 PCP copay/ $25 specialist copay
Coverage is provided for services for the treatment of disease or injury to the eye. Routine vision services other than routine screening included as part of a routine physical are not covered. • Corrective lenses, contacts and frames are only covered following cataract surgery. • One pair of intraocular lenses is covered following cataract surgery. • Deluxe intraocular lenses are payable up to the allowance of the base model.	
Nutritional counseling	**100%,** after $25 copay
Nutritional counseling is covered only for Diabetic Education.	
Foreign care All services received while out of the country, as long as they are covered services under the plan, will be covered at the in-network level of benefits. The claim is converted to local currency at the exchange rate in effect at the time the claim is processed.	

What is Not Covered

Here are examples of expenses not covered.

- Care, treatment, services or supplies that are not medically necessary, as determined by Anthem.
- Care, treatment, services or supplies that are not prescribed, recommended and approved by your attending physician or dentist.
- Use of an ambulatory surgical facility for dental procedures, unless such use is medically necessary.
- Anesthesia when:
  - A separate charge is made and anesthesia is administered by a surgeon or assistant surgeon in connection with surgery.
  - It is administered by the same physician who administers electroshock therapy.
  - It is rendered in connection with a service that is not a covered service.
- Regular dental care and treatment, such as:
  - Preventive care, including fillings.
  - Removal or replacement of teeth.
  - Fluoride treatment.
  - Dental services related to the gums.
  - Apicoectomy (dental root resection).
  - Appliances to correct temporomandibular joint (TMJ) disorder.
  - Orthodontics.
  - Root canal treatment.
  - Soft tissue impactions.
  - Alveolectomy, augmentation and vestibuloplasty.
  - Treatment of periodontal disease.
  - Prosthetic restoration of dental implants.

- The replacement of durable medical equipment due to loss or negligence, or because a newer or more efficient model is available.

- In-hospital visits for customary preoperative and postoperative care.

- In-hospital visits by a physician in excess of one visit per day per specialty.

- A preoperative work-up by the surgeon who performs or assists with major surgery, except for charges for a separate consultation when rendered in connection with minor or diagnostic surgery.

- Staff consultations required by hospital rules.

- Replacement of a prosthesis, except as specifically provided, including replacement of an outdated prosthesis that the EPO administrator determines still is functional or able to be repaired.

- Items that are considered capital improvements to the home, such as electrical wiring and plumbing, regardless of whether such improvements constitute medical care under the Internal Revenue Code.

- Plastic surgery, reconstructive surgery, cosmetic surgery or other services or supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons. Cosmetic surgery will be covered only if it results in improved bodily function or as described under “Other services.” However, complications resulting from elective procedures are covered.

- Surgical treatment for weight reduction or control, unless there is a diagnosis of morbid obesity, and it is approved by Anthem. See the “Medical plan contacts” section for contact information.

- Care in an institution that is primarily for convalescent or domiciliary care, or custodial care, such as a place of rest, a home for the aged, a nursing home, a half-way house or a hotel.

- Diagnostic X-rays and laboratory and machine tests not consistent with the diagnosis, symptoms or illness.

- Athletic club dues or exercise equipment for the home.

- Sex-transformation surgery and follow-up care, and treatment of gender-identity problems.

- Reversal of a sterilization procedure.

- Services or supplies that are not necessary, as determined by Anthem, for the diagnosis, care or treatment of the disease or injury involved. This applies even if such services or supplies are prescribed, recommended or approved by the person’s attending physician or dentist.

- Services or supplies for sexual dysfunction or inadequacies that do not have a physiological or organic basis.

- Services or supplies that Anthem determines are educational or developmental services or supplies, or for education or job training.

- Except in special circumstances as determined by Anthem, inpatient private duty nursing services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).

- Services recommended by a nonprofessional or services performed at your request.

- Chiropractic care, developmental therapy, physical therapy, speech therapy and other therapy services for maintenance after the optimum level of improvement has been reached, as determined by Anthem.

- Eye surgery to correct refractive errors.

- Marriage, family, child, career, social adjustment, pastoral or financial counseling, except as provided in the "Mental health and substance abuse coverage" section.

Charges by Certain Providers

- Charges of a physician or other professional provider on "stand-by" in the event complications might occur.

- Surgical or routine maternity care visits while hospitalized, to the extent those visits are considered part of the surgeon's or obstetrician's fee, as determined by Anthem.

- The administration of anesthesia by the surgeon, assistant surgeon or physician who also renders diagnostic tests, performs surgery or provides any other services for the same procedure.

- Professional services provided to you by a family member or by a person residing in your home.

Routine or Convenience Items

- Routine foot care (such as removal of corns and calluses, orthopedic shoes, insoles and arch supports).

- Routine eye examinations, eyeglasses, contact lenses and eye refractions for the fitting of glasses, except as specifically provided under the plan.

- Routine hearing examinations, except as specifically provided under the plan.

- Routine dental examinations.

- Vitamins, food and food supplements used as dietary supplements, except as provided under the prescription program or except if prescribed while hospitalized and taken on an inpatient basis as medically necessary.

- Personal comfort or beautification items while hospitalized, such as TV rentals, barber services and guest meals.

- Inoculations, vaccinations, immunization shots, preventive gammaglobin shots, etc., except as specifically provided under the plan.
- Diversional or recreational therapy.
- Convenience items, even when prescribed by the physician or provided by a hospital, if not medically necessary for treatment of your medical condition.
- Miscellaneous equipment, including:
  - Air conditioners.
  - Bed rails, tables, trays or boards (except if an integral part of the hospital bed).
  - Bicycles.
  - Children's strollers.
  - Dietetic or health foods.
  - Electric fans.
  - Enuresis units.
  - Escalator or elevator for your home.
  - Food liquidators.
  - Hand rails.
  - Heating pads.
  - Heating units for swimming pools.
  - Humidifiers.
  - Hypo-allergenic cosmetics or toiletries.
  - Ice bags.
  - Mattresses, except when purchased with a hospital bed.
  - Niagra vibrators.
  - Overbed tables.
  - Puritron air fresheners.
  - Ramps.

— Scales (weight).

— Telephones.

— Thermometers.

— Vaporizers.

— Walking canes with seat.

— Wig styling.

Other Exclusions

- Charges that are more than the network negotiated fee, maximum allowed amount, or in excess of any applicable annual maximum, as determined by Anthem.
- Services or supplies for which there is no legal obligation to pay, unless otherwise required by federal law.
- Services for which the physician or other provider does not customarily bill his or her patient.
- Charges that are made only because there is health coverage.
- Services or supplies provided because of injury or illness due to an act of declared war in the United States.
- Hospitalization that begins before the effective date of your coverage or after your coverage has ended, except as specifically provided.
- Hospital room, board and ancillary services or supplies, when hospital confinement is or becomes primarily rehabilitative, except as specifically provided, unless your diagnosis and condition is such that rehabilitation cannot be provided on an outpatient basis.
- Use of a facility that is part of a hospital or an approved skilled nursing facility is covered when rehabilitation is medically necessary, as determined by Anthem, due to an accidental injury, spinal injury or an illness such as a stroke.
- Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy.
- Any service or supply rendered before the effective date of coverage or after coverage has ended.
- Charges for maintaining an environment suitable for preventing the worsening of a medical condition.
- Admitting fees, deposits, telephone consultations, telemedicine, missed appointments and completion of claim forms.

- Services or supplies covered under any federal or state “no-fault” motor vehicle insurance provision that relates to medical treatment or other mandated insurance, regardless of whether you properly assert your rights under the motor vehicle insurance contract.

- Services or supplies for which you recover the cost by legal action, insurance proceeds or settlement from a third party whose negligent or wrongful actions have caused or are alleged to have caused your illness or injury, or from the insurer of the third party.

- Services or supplies that are furnished, paid for or otherwise provided by a local, state or federal governmental agency, except as otherwise required by law.

- Services or supplies that are furnished, paid for or otherwise provided or required for treatment of a military service-connected disability or because of the present service of any person in the armed forces of a government.

- Services or supplies provided for any condition covered by Workers’ Compensation laws, or for any other occupational condition, ailment, injury or illness occurring on the job, if:

  — Your employer provides reimbursement for these charges.

  — Your employer makes a settlement for these charges.

  — You fail to assert your rights in attaining reimbursement from the employer.

  This exclusion applies to all covered persons. The EPO has the right to recover or place a lien on any benefits paid or payable if Workers’ Compensation provides benefits for the same condition.

Mental Health and Substance Abuse Treatment Coverage

You have access to medically necessary treatment for mental health disorders and substance abuse. Coverage is provided through Anthem's Behavioral Health program. Your expenses are not covered by the EPO option if you use providers who do not participate in the Anthem BlueCard PPO network.

Medically Necessary

Determining medical necessity is a complex process that includes the application of Anthem's level of care guidelines and an analysis of the nature and severity of the patient's clinical status and the appropriateness and effectiveness of the proposed treatment plan. The requested services provide for the diagnosis and/or active treatment of a covered current DSM-IV mental or substance-related disorder provided by a mental health/substance abuse professional licensed to practice independently who meets Anthem's credentialing standards.

Medically necessary means health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are all of the following:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not primarily for the convenience of the patient, physician or other health care provider.
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

How Anthem's Behavioral Health Program Works

Anthem provides treatment through a network of licensed psychiatrists, therapists, treatment centers and hospitals that must meet strict membership requirements. Anthem regularly reviews its providers to make sure that standards are met. See the "Accessing your benefits information" section for information on how to get a list of providers.

What Is Covered Under Mental Health and Substance Abuse Treatment

Anthem covers the following mental health and substance abuse treatment. To receive benefits for intensive and intermediate levels of care, you must obtain authorization from Anthem at the toll-free number shown on your medical ID card. A clinical care manager will assess your situation and refer you to participating providers.

In the event of a psychiatric emergency, use the most convenient emergency facility – regardless of whether the facility is a network facility. Within 48 hours of admission or the next business day, if sooner, you, a family member, or a representative of the facility, must contact Anthem to certify care. Anthem will determine if benefits are payable.

Outpatient treatment does not require pre-certification, however we recommend that you contact Anthem's Behavioral Health Resource Center listed on you ID card to:

- Receive guidance on the best use of your benefit, including referrals to qualified in-network providers.
- Receive information about other programs, services and tools that can support your mental health and wellness.
- Address any questions that you may have regarding your mental health and substance abuse benefit.

If there are multiple diagnoses, your benefit will pay only for the treatment of diagnoses that are identified in the current edition of *The Diagnostic and Statistical Manual of the American Psychiatric Association* (APA). Benefits include detoxification from abusive chemicals or substances when necessary to protect your health. APA's website is www.apa.org.

If Anthem determines that an inpatient stay is required, it is covered on a semiprivate room (a room with two or more beds) basis.

Covered Mental Health and Substance Abuse Treatment

Receive guidance on the best use of your benefit, including referrals to qualified in-network providers.

Covered mental health and substance abuse treatment	EPO option pays using network providers
Inpatient hospital treatment	**100%,** after $150 hospital admission copay
Outpatient treatment	**100%,** after $20 copay per visit
Partial hospitalization	**100%,** after $20 copay per visit

To be covered, treatment programs must:

- Provide evaluation, diagnostic and counseling services.
- Be licensed and accredited, if required.
- Comply with any local laws governing treatment programs.
- Be medically necessary.

How Benefits Are Paid

To receive inpatient benefits, you must call and get authorization in advance of any treatment. See the "Medical plan contacts" section for contact information. Without authorization, you risk your claim being denied as not covered even if you use network providers.

What Is Not Covered

The following services and supplies are not covered under the mental health and substance abuse treatment program:

- Any services you receive from providers outside of the Anthem network, except in emergency situations when prior authorization is obtained.
- For out-of-network services that are pre-certified by Anthem, any charges in excess of the maximum allowed amount as determined by Anthem.
- Administrative psychiatric services when these are the only services rendered.
- Bioenergetic therapy.
- Carbon dioxide therapy.
- Chart review.
- Confrontation therapy.
- Consultations with a mental health professional for adjudication of marital, child support and custody cases.
- Eating disorder and gambling programs based solely on the 12-step model.
- Educational evaluation/remediation therapy and school consultations.
- Erhard Seminar Training (EST) or similar motivational services.
- Expressive therapies (art, poetry, movement, psychodrama).
- Primal therapy.

- Private duty nursing.
- Private rooms (except when required for infection control).
- Transcendental meditation.
- Treatment of sexual addiction, co-dependency or any other behavior that does not have a DSM-IV diagnosis.
- Mental and psychoneurotic disorders not listed in the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-9).
- Court-mandated or legally mandated treatment that is not considered clinically necessary, as determined by Anthem, or that would not otherwise be covered.
- Services or supplies that are determined by Anthem not to be clinically necessary, including any confinement or treatment given in connection with a service or supply that is not clinically necessary.
- Services or supplies you receive before you became covered under the EPO.
- Treatment for any of the following diagnoses: mental retardation (except the initial diagnosis), autism, pervasive developmental disorders, chronic organic brain syndrome, learning disabilities or transsexualism.
- Failure to submit completed claim forms.
- Missed appointments.
- Custodial care.
- Ecological or environmental medicine, diagnosis or treatment.
- Education, training and room and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Wilderness programs and equine therapy.
- Herbal medicine or holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of your immediate family:
  - Your spouse, child, brother, sister, parent or grandparent.
  - A child, brother, sister, parent or grandparent of your spouse or domestic partner.

- Services, supplies, treatments or drugs that have not been scientifically proven to be a treatment option or have not been certified by the U.S. Food and Drug Administration (FDA) because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, services or supplies.

- Services or supplies for which you are not legally required to pay.

- Membership costs for health clubs, weight loss clinics and similar programs.

- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualify as mental health or substance abuse treatment.

- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-clinically necessary purposes and related expenses for reports, including report presentation and preparation.

- Services given by a pastoral counselor.

- Personal convenience or comfort items including, but not limited to, televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.

- Private duty nursing services while confined in a facility.

- Sensitivity training, educational training therapy or treatment for an education requirement.

- Stand-by services required by a physician.

- Telephone consultations.

- Tobacco dependency.

- Services or supplies received because of war, declared or undeclared or international armed conflict.

- Mental health treatment for weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.

- Services given by volunteers or persons who do not normally charge for their services.

- Care received in a residential treatment center.

Prescription Drug Program for the EPO Option

Your prescription coverage includes:

- A retail prescription benefit.
- A mail-order benefit.

For the EPO option, there is an out-of-pocket expense maximum for mail-order pharmacy prescriptions under the prescription drug program. The limit varies by year ($600 in 2013; $700 in 2014). In 2015 and each calendar year thereafter, the annual out-of-pocket maximum will increase by 6 percent when compared to the annual out-of-pocket maximum for the prior calendar year. Any expenses you incur as a result of paying the difference between the cost of a brand-name and a generic drug when a generic equivalent is available will not count toward the out-of-pocket maximum.

The retail and mail-order prescription benefit is administered by Express Scripts.

Prescription Drug Program Overview

The following chart provides an overview of the benefits payable under the prescription drug program:

Prescription Drugs	**Using a Participating Pharmacy**	**Using a Non-Participating Pharmacy**
Retail Pharmacy (supply appropriate for up to 30 days of therapy)		
Annual Deductible	No deductible required	$50 combined for generic and brand-name drugs
Coinsurance		
Generic Drugs	• You pay the discounted network price (DNP), but no more than an $8 copay in 2013 and 2014 and $9 copay in 2015 per prescription • Once you obtain three fills of a prescription for a maintenance medication from an in-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP. Fixed dollar maximum copays will not apply	After the deductible is met, you pay 100% of the cost difference between the DNP and retail cost. **In addition:** • You pay 30% of the DNP cost for the original prescription and each refill • Once you obtain three fills of a prescription for a maintenance medication from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP

Prescription Drugs	Using a Participating Pharmacy	Using a Non-Participating Pharmacy
Single-Source Brand-Name Drugs (No Generic Available)	• You pay 30% of the DNP but no more than a $25 copay per prescription for each of 2013 and 2014[1] • Once you obtain three fills of a prescription for a maintenance medication from an in-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP and maximum dollar copays will not apply	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. **In addition**: • You pay 40% of the DNP for the original prescription and each refill • Once you obtain three fills of a prescription for a maintenance medication from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP
Multi-Source Brand-Name Drugs (When Generic Is Available)	• If you purchase a brand-name drug when a generic equivalent is available, you pay the generic equivalent DNP but no more than an $8 copay per prescription in 2013 and 2014 and $9 in 2015, **plus** 100% of the cost difference between the brand-name and generic drug (fixed dollar maximum copay does not apply)[2] • Once you obtain three fills of a prescription for a maintenance medication from an in-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP and maximum dollar copays will not apply	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. **In addition**: • If you purchase a brand-name drug when a generic equivalent is available, you will pay 30% of the generic equivalent DNP plus 100% of the cost difference between the brand-name and generic drug[2] • Once you obtain three fills of a prescription for a maintenance medication from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP
Mail Service Pharmacy (supply appropriate for up to 90 days of therapy)		
Generic Drugs	You pay the DNP per prescription, but no more than a $16 copay in 2013 and 2014 and $18 copay in 2015	None
Single-Source Brand-Name Drugs (No Generic Available)	You pay 30% of the DNP, but no more than a $50 copay per prescription for 2013 and 2014[1]	None

Prescription Drugs	Using a Participating Pharmacy	Using a Non-Participating Pharmacy
Multi-Source Brand-Name Drugs (When Generic is Available)	You pay the DNP per prescription but no more than a $16 copay in 2013 and 2014 and $18 in 2015, plus 100% of the cost difference between the brand-name and generic drug (fixed dollar maximum copay does not apply) [2]	None

[1] For 2015 and each calendar year thereafter, the maximum per prescription copay will increase by 6% when compared with the maximum copay for the prior plan year.
[2] Does not apply for brand-name drugs where there is a generic equivalent and the claims administrator approves your doctor's certification that you are medically unable to take the generic version of the medication. If the claims administrator approves your request, the cost-sharing that applies to brand-name drugs with no generic available will apply.

Retail Prescription Benefit

You can get up to a 30-day supply of medication at a retail pharmacy. It is your decision to use either a participating or non-participating pharmacy each time you need short-term medications.

Using a Participating Pharmacy

When you use a participating pharmacy, you pay:

- For a generic drug, you'll pay the discounted network price (DNP) for each prescription drug, but no more than an $8 copay in 2013 and 2014 and a $9 copay in 2015.

- For single-source and multi-source brand-name drugs, you'll pay 30 percent of the DNP (but no more than a $25 copay) for each prescription in 2013 and 2014. The maximum copay will increase by 6 percent per year, when compared with the maximum copay for the prior plan year, for the years 2015 and beyond. If you choose a brand-name drug when a generic equivalent is available, you'll pay an amount equal to the generic equivalent DNP up to a maximum copay of $8 per prescription in 2013 and 2014, and $9 in 2015, plus 100 percent of the cost difference between the brand-name and the generic drug; the fixed dollar maximum copays do not apply. You will not have to pay the cost difference between the brand-name and the generic drug if your doctor certifies that you are medically unable to take the generic version of the medication and such exception is approved by Express Scripts' procedures for approval of treatment or services and instead, you will pay 30 percent of the brand-name DNP, subject to the maximum copay.

  Example: You select a brand-name drug with a DNP of $20. This particular brand-name drug also has a generic equivalent with a DNP of $10. In this example, in 2013, you would pay an **$8** copay **plus** the cost difference between the brand-name and generic drug ($20 minus $10 which is equal to **$10**). Your total cost would be **$18**.

- Once you obtain three fills of a prescription for a maintenance medication from a participating pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 50 percent of the DNP; the fixed dollar maximum copays will not apply. This requirement applies regardless of whether you are purchasing a generic, single-source, or multi-source brand -name drug.

- The DNP is a negotiated price, which generally is lower than the retail price of the drug. To ensure you receive the discounted network price, you will need to show your ID card at the time of purchase.

If your doctor prescribes more than a 30-day supply, the maximums do not apply and you are responsible for the cost of the additional supply.

You pay your share of the bill at the pharmacy, so you do not need to file a claim form.

Using a Non-Participating Retail Pharmacy

When you use a non-participating pharmacy, you pay an annual $50 per person prescription deductible, combined for generic and brand-name drugs. After the annual deductible is met, you also pay:

- For generic drug expenses, you'll pay 30 percent of the DNP for each prescription. In addition, you pay 100 percent of the cost difference between the DNP and retail cost.

- When you purchase a single-source or multi-source brand-name drug, you'll pay 40 percent of the DNP for each prescription drug. In addition, you'll pay 100 percent of the cost difference between the DNP and the retail cost. If you choose a brand-name drug when a generic equivalent is available, you'll pay 30 percent of the generic equivalent DNP for each prescription plus 100 percent of the cost difference between the brand-name retail cost and generic drug DNP. You will not have to pay the cost difference between the brand-name and generic drug (and the single-source and multi-source brand-name drug coverage will apply) if your doctor certifies that you are medically unable to take the generic version of the medication, and this exception is approved by Express Scripts' procedures for approval of treatment or services and instead, you will pay 40 percent of the brand name DNP, subject to the maximum copay.

  Example: You select a brand-name drug with a DNP cost of $50. This brand-name drug has a retail cost of $75. This particular brand-name drug also has a generic equivalent with a DNP cost of $20 and a retail cost of $35. In this example, in 2013, you would pay **$6** (30% of the generic equivalent DNP of $20) **plus** the cost difference between the brand-name retail cost and generic drug DNP ($75 minus $20 which is equal to $55). Your total cost would be **$61** (in addition to all or any portion of the annual $50 deductible that applies).

- Once you obtain three fills of a prescription for a maintenance medication from an non-participating pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 50 percent of the DNP.

Your costs could be much higher based on the retail cost of the drug.

You pay the full bill at the pharmacy and file a claim for reimbursement.

Mail-Order Prescription Benefit

You can obtain up to a 90-day supply of medication delivered to your home by mail. When you do:

- For a generic drug, you'll pay the DNP for each prescription drug, but no more than a $16 copay in 2013 and 2014 and an $18 copay in 2015.

- For a single-source or multi-source brand-name drug, you'll pay 30 percent of the DNP for each prescription drug, but no more than a $50 copay in 2013 and 2014. The $50 maximum copay will increase by 6 percent per year, when compared with the maximum copay for the prior plan year, for the years 2015 and beyond. If you choose a brand-name drug when a generic equivalent is available, you'll pay an amount equal to the DNP up to a maximum of $16 in 2013 and 2014, and $18 in 2015, plus 100 percent of the cost difference between the brand-name and generic drug; the fixed dollar maximum copays do not apply. You will not have to pay the cost difference between the brand-name and the generic drug (and the single-source and multi-source brand-name drug coverage will apply) if your doctor certifies that you are medically unable to take the generic version of the medication and this exception is approved by Express Scripts' procedures for approval of treatment or services.

There is no deductible for mail-order prescriptions.

Initial Orders

There are three ways to order a prescription by mail:

- Access Express Scripts' website (www.express-scripts.com/verizon) and follow the instructions to transfer an existing retail prescription to mail.

- Send your original prescription and your payment to Express Scripts using a mail order form.

- Have your doctor call 1-888-EASYRX1 (1-888-327-9791) for instructions on faxing the prescription.

- For the fastest service, ask your doctor to send the prescription directly to Express Scripts by e-prescribing.

Your prescription will be sent to your home by United States Postal Service mail or UPS within 14 days of the date that you mailed the prescription to Express Scripts.

If you can't wait two weeks to receive your medication, ask your physician to write two prescriptions – one that you can use at your local pharmacy and one for your ongoing supply that you can use for the mail-order pharmacy.

Note: Medications cannot be mailed outside the United States.

Refills

There are three ways to order refills:

- Access Express Scripts' website (www.express-scripts.com/verizon) and follow the instructions for refilling prescriptions.
- Call Express Scripts at the number listed on your ID card.
- Mail your refill slip to Express Scripts using an order envelope.

What Is Covered

The prescription program covers the following items. If you have questions about covered charges, you should contact Express Scripts. See your ID card for contact information.

- Medications that require a prescription and that are medically necessary.

  Medically necessary means appropriate with regard to general medical standards and effective in prevention, diagnosis or treatment according to accepted clinical evidence, as determined by the claims administrator.

- Biologicals, immunization agents and vaccines.
- Allergy sera, at a retail pharmacy.
- Diabetes therapy.
  - Insulin needles and syringes.
  - Diabetic kits (insulin, apparatus and supplies), available through Express Scripts. You pay a single payment when the order is placed as one prescription on the same day with insulin or other oral agents. If you request the medication and supplies be refilled, but part of the request is made too soon, then the prescriptions will not be dispensed together.
  - Over-the-counter insulin and diabetic supplies ordered separately (not as a kit).
- Medications with special considerations. Some medications in the following treatment categories have limitations or considerations for age, gender or supply amounts.
  - Premenstrual conditions.
  - Asthma.
  - Erectile dysfunction.
  - Acne (only under the HCN option).
  - Flu prevention and treatment.

- Contraceptives.
- Cancer.
- Hormone replacement.

- Exempt infant formula when it is medically necessary for infants who have been diagnosed with medical or dietary problems.

Special Purchase Requirements for Certain Medications

Special requirements apply for the purchase of certain medications. For example:

- Before dispensing medications with the potential of drug interaction with other drugs, the prescription program will alert the pharmacist who will determine if the doctor should be contacted.

- After clinical reviews are performed, patients who potentially may be overusing highly addictive narcotics may be limited to purchasing their medications at one participating retail pharmacy of their choice and through mail order.

Generic Medications

Generic prescription drugs have the same chemical makeup, but usually cost less, than brand-name drugs. In fact, using a generic can save you hundreds of dollars each year. If you take medication – or are being prescribed a drug for the first time – be sure to ask your doctor if the medication is available as a generic.

Compound Medications

Compound medications are custom made by a pharmacy according to a doctor's prescription. Often, these medications are made up of several ingredients, each with its own, unique identification number, called a National Drug Code (NDC).

Special rules apply for submitting claims for compound medications. See the "Filing Prescription Claims" section for more information.

Medications That Require a Coverage Review

Certain medications must undergo a coverage review before they are covered under the prescription program.

If you have a prescription that needs this review, the pharmacist will coordinate with the prescribing doctor. If you have a question about whether a medication will require a coverage review, call Express Scripts. For faster approval or if you or your doctor has a question, you or your doctor can contact the Express Scripts coverage review unit (see your ID card for contact information). Usually, approval takes two to three business days to process a request for review.

Generally, medications are selected for coverage review before dispensing if:

- The medication is often associated with complications.
- The medication has a high potential for adverse reactions.
- More information is needed to determine whether the drug meets the Plan's coverage criteria.
- The medication is needed to treat complex conditions.
- The medication is effective only for some individuals or with other therapies.
- The medication is costly and has the potential for misuse.

Examples of drugs subject to a coverage review include those in the categories listed below. The list changes from time to time as new drugs are approved, new clinical guidelines for appropriate use are developed or problems are identified.

- Acne therapy.
- Alzheimer's therapy.
- Anticonvulsants (seizure medication).
- Appetite suppressants and other weight loss medications.
- Cancer medications (Lupron).
- Erectile dysfunction medications.
- Erythroid stimulants (correct anemia in patients with dialysis, HIV, etc.).
- Hepatitis C therapy.
- Hereditary angioedema.
- Human growth hormones.
- Interferons (used to treat immune disorders and infections).
- Miscellaneous dermatologicals.
- Myeloid stimulants (used to fight infection and treat low white-blood cell counts).
- Platelet proliferation stimulants.

Quantity Dispensing Limits

Some medications are limited to specific quantities, such as the number of pills or total dosage. The quantity is based on guidelines approved by the U.S. Food and Drug Administration and published by the manufacturer, as well as accepted medical practice. If your medication is prescribed for quantities or doses outside these guidelines, a coverage review may be required to determine whether the medication meets the Plan's coverage criteria.

When a review is complete, Express Scripts will notify you and your doctor of the decision. If coverage is approved, the letter will inform you of the length of time of your coverage approval. If the medication is not covered under the Plan, the letter will include the reason for the denial and how to submit an appeal if you choose.

Examples of categories of prescription drugs that have limits include the following:

- Anti-influenza agents.
- Cholesterol medications (Crestor).
- Erectile dysfunction agents.
- Hereditary angioedema agents.
- Migraine medications.

What Is Not Covered

Under the EPO option, the prescription drug program does **not** cover:

- Medications not approved by the U.S. Food and Drug Administration (FDA).
- Medications that states restrict for sale or distribution.
- Medications that are not medically necessary or that do not treat an accidental injury, illness or pregnancy, except those identified under "What Is Covered."
- Appetite suppressants and other weight loss drugs, unless for treating morbid obesity and taken in conjunction with a patient support program.
- Therapeutic devices, bandages, heat lamps, braces or artificial appliances. However, the Plan may cover insulin needles and syringes, over-the-counter diabetic supplies (unless covered by Medicare), and diaphragms and IUDs that require a prescription.
- Health and beauty aids and medications for cosmetic purposes, such as Renova, Retin-A or Solage for age spots or as a wrinkle cream, and Propecia or Rogaine for hair loss.
- Charges for the administration or injection of any drug.
- Medications for experimental use.

- Medication covered by Workers' Compensation laws or similar government programs, or for which no charge is made.

- Charges covered by Medicare, including both Medicare Part A and Part B – regardless of whether or not you have enrolled in or received Medicare Part A and Part B benefits.

- Blood or blood plasma.[1]

- Medication you receive in a hospital or outpatient surgical center.[1, 2]

- Medication you receive while you are a patient in a skilled nursing facility or similar institution when medications provided by those institutions are covered by a medical plan, including Medicare.[1, 2]

- Prescriptions refilled in excess of the number of times the doctor specified or any refill dispensed after one year from the doctor's original order.

- Mifeprex, for termination of intrauterine pregnancy.

- Over-the-counter (OTC) medications and their equivalents available by prescription (except for insulin, diabetic supplies and products included in the Affordable Care Act).

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[1] May be covered under the Verizon Medical Plan. Claims should be submitted to the appropriate claims administrator.

[2] Medications administered while you are an inpatient at a hospital, skilled nursing care facility or similar facility generally are covered under your medical option – not the prescription drug program. However, prescriptions filled at a pharmacy associated with a personal care facility, such as a nursing home, are covered under the prescription program. Benefits are based on whether the retail pharmacy is a participating or non-participating pharmacy.

Filing Claims

Medical Claims

When you receive care from network providers, you do not have to file claims.

If you receive care from a provider who is not in the EPO network (for example, in the event of certain emergencies), you will need to file a claim and send copies of your bills and receipts to Anthem. See the "Medical plan contacts" section for contact information. Keep in mind that the EPO usually does not cover any out-of-network care. If out-of-network care is approved, it will be based on "maximum allowed amount" charges instead of network negotiated fees.

If your claim is denied, you have a right to appeal. See the "Claims and Appeals Procedures" section in "Your Medical Coverage" summary plan description (SPD) for information on filing an appeal. See the "Accessing your benefits information" section for information on how to access your SPD.

Mental Health and Substance Abuse Claims

If you receive preapproved in-network care, you do not have to file claims. Anthem Behavioral Health providers automatically will submit claims on your behalf. If you receive care from a provider who is not in the Anthem network (for example, in the event of certain emergencies), you will need to file a claim and send copies of your bills and receipts to Anthem Behavioral Health. See the "Medical plan contacts" section for contact information. Keep in mind that the EPO usually does not cover any out-of-network care. If out-of-network care is approved, it will be based on the "maximum allowed amount" instead of network negotiated fees.

If your claim is denied, you have a right to appeal. See the "Claims and Appeals Procedures" section in your "Medical Benefits" SPD for information on filing an appeal. See the "Accessing Your Benefits Information" section for information on how to access your SPD.

Prescription Drug Claims

If you use a participating retail pharmacy or mail order, you do not have to file claims. You need to show your ID card when you use a participating retail pharmacy.

If you use a non-participating retail pharmacy, you need to submit claims to Express Scripts.

If your claim is denied, you have a right to appeal. See the "Claims and Appeals Procedures" section in your "Medical Benefits" SPD for information on filing an appeal. See the "Accessing Your Benefits Information" section for information on how to access your SPD.

Claims for Compound Medications

There are two ways to submit claims for compound medications:

- Take the prescription to a participating retail pharmacy, and ask the pharmacist to submit the claim directly to Express Scripts so that you only need to make your copay at the time of service. If you use mail order, no claims need to be submitted. Please note, however, that mail-order pharmacies can fill only certain prescriptions for compound medications. Contact Express Scripts to determine which medications can be filled. See your ID card for contact information.

- If you paid the entire cost of your compound medication, you will need to submit a claim form to Express Scripts to receive reimbursement.

  You must send in your pharmacy receipt, as well as a list of all the ingredients in the medication and each ingredient's National Drug Code (NDC), which your pharmacist can provide. (See the claim form for details.)

  If you submit a claim, you will be responsible for any cost differences between what the pharmacy charges and what the plan allows for reimbursement.

If your claim is denied, you have a right to appeal. See the "Claims and Appeals Procedures" section in your "Medical Benefits" SPD for information on filing an appeal. See the "Accessing Your Benefits Information" section for information on how to access your SPD.

Medical Terms to Know

BlueCare Consultant
A dedicated clinical contact at Anthem who is available to you and your family to provide education and support to address issues, needs or concerns that you may have.

If you have a chronic or complex health condition, you may be assigned a primary nurse who will call you to assess your progress and provide you with information and education.

Brand-Name Drug
Brand-name drugs are patented by their manufacturers, so only their makers can sell them – usually at a high retail price. But when the patent expires, these same drugs can be produced as generics by other makers, who often sell them at a much lower price.

Clinically Necessary
Services or supplies that meet the following requirements are clinically necessary:

- They are consistent with the signs and symptoms of diagnosis and treatment of the behavioral disorder, psychological injury or chemical dependency.
- They are consistent with standards of good clinical practice.
- The care provides the desired results at an adequate level of service that can be safely provided.

Services and supplies may not be considered clinically necessary even if a provider prescribes them.

Copay
A fixed dollar amount you pay for certain services or supplies.

Custodial care
Custodial care is made up of services and supplies that meet one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of the above conditions is custodial care regardless of any of these:

- Who recommends, provides or directs the care.
- Where the care is provided.

- Whether or not the patient, or another caregiver, can be or is being trained to care for himself or herself.

Doctor or physician

The definition of doctor includes a doctor of chiropody (D.P.M. or D.S.C.), doctor of chiropractic (D.C.), doctor of dental medicine (D.M.D.), doctor of dental surgery (D.D.S.), doctor of medicine (M.D.), doctor of osteopathy (D.O.) and doctor of podiatry (D.P.M.).

A physician is a licensed, practicing physician acting within the scope of his or her license.

Educational or developmental

Educational or developmental services or supplies provide training in daily living activities, instruction in scholastic skills such as reading and writing, preparation for an occupation, treatment for a learning disability or promotion of the development beyond any functional level previously demonstrated.

Experimental or investigational

Any service or supply determined by the option administrator to be for experimental or A service or supply, the medical use of which still is under study and is not yet recognized throughout the medical profession in the United States as safe and effective for diagnosis and treatment, as determined by the claims administrator. This includes but is not limited to:

- All phases of clinical trials.
- All treatment protocols based on or similar to those used in clinical trials.
- Drugs approved by the U.S. Food and Drug Administration (FDA) under its Treatment Investigational New Drug regulation.
- FDA-approved drugs used for unrecognized treatment indications.

A drug, device, procedure or treatment is determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer review literature to substantiate its safety and effectiveness for the illness or injury involved.
- If approval is required by the FDA, such approval has not been granted for marketing.
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocol or protocols or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Generic Drug
A prescribed medication that is chemically equivalent to a brand-name medication that no longer is under patent protection.

Illness
A nonoccupational bodily disorder.

Injury
A nonoccupational bodily injury.

Maximum allowed amount
For covered services you receive from an out-of-network provider, the Maximum Allowed Amount will be one of the following as determined by Anthem BCBS:

- The amount based on Anthem BCBS's non-participating provider fee schedule/rate, which is established under Anthem BCBS's discretion, and which Anthem BCBS reserves the right to periodically modify after considering one or more of the following:

  — Reimbursement amounts accepted by like/similar providers contracted with BlueCross and BlueShield

  — 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

- 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

- 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

- An amount negotiated by Anthem BCBS or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or

- An amount equal to the total charges billed by the provider, but only if such charges are <u>less than</u> the Maximum Allowed Amount calculated by using one of the methods described above.

Unlike network providers or participating providers, out-of-network providers may send you a bill and collect for the amount of the provider's charge that exceeds Anthem BCBS's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the provider charges. This amount can be significant. Choosing a network provider or participating provider will likely result in lower out of pocket costs to you

Medically Necessary

Benefits are payable under the Plan only where the care, treatment, services or supplies are required of the necessary treatment of an injury, illness, or pregnancy, as distinct from those which are unnecessary or experimental/investigational. The respective claims administrator will apply this standard, as described here, and has the discretion to apply this standard, based upon the facts and circumstances of each individual case. These applications are applied solely for the purpose of determining Medical Plan benefits and not for determining what type of medical care should be provided; all decisions related to the type of medical care to be provided shall be made independently by the covered person and the covered person's physician.

Mental Health Disorders and Treatment

A mental health disorder is a disorder that, in manifestation, cause, symptoms or treatment, is mental in nature. This includes nervous disorders, neuroses, psychoneuroses, psychopathies, psychoses, personality disorders (classified as an Axis I Disorder in the *Diagnostic and Statistical Manual of Mental Disorders* [Fourth Edition-Text Revision] by the American Psychiatric Association [DSM-IV-TR]), and any other mental or emotional disease or disorder.

The mental health disorder also must:

- Involve a clinically significant behavioral or psychological syndrome or pattern.
- Be associated with a painful symptom, such as distress.
- Impair a person's ability to function in one or more major life activities.

The EPO option covers mental health treatment for mental health disorders, illness, emotional disturbance or behavioral problems that are diagnosed by a licensed mental health professional.

Morbid Obesity

Surgery to assist in weight loss (bariatric surgery) is a covered benefit. This surgery requires pre-certification and is also subject to review for medical necessity according to Anthem's medical policy. This surgery is considered medically necessary when the member meets Anthem's medical policy, including but not limited to:

- The member has a BMI of 40 or greater or the member has a BMI of 35-39.9 and has a significant medical problem that is linked to being overweight (for example, sleep apnea, heart disease, high blood pressure or diabetes); and the member has documentation of failed multiple prior nonsurgical ways to try to lose weight; **and**
- The planned surgery is part of a complete program that includes patient evaluation (medical, nutritional, psychological), thorough education in the planned procedure (including risks, benefits and required lifestyle changes), and comprehensive post-surgical care (including nutritional and psychological support).

  Additional information regarding requirements for this surgery can be obtained from a Blue Care Consultant, who can address your unique situation.

Network Negotiated Fee (NNF)
A network negotiated fee is the fee a network provider has agreed to accept as payment in full for covered services or supplies provided on an in-network basis.

Participating EPO Providers
A provider or health care provider who participates within the Anthem BlueCard PPO network. See the “Accessing your benefits information” section to get a list of providers.

Substance Abuse
The nonmedical or recreational use of substances that alter the state of consciousness.

Treatment Facility
A treatment facility must meet all of these conditions:

- Is legally licensed as a hospital.
- Provides a broad range of 24-hour-a-day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of physicians.
- Provides 24-hour-a-day nursing care by, or under the direction of, a licensed registered nurse (R.N.).
- Has organized facilities for surgical and medical diagnosis and treatment.

In no event does the term “hospital” include a convalescent nursing home or an institution or part thereof that is any of these:

- Used primarily as a convalescent facility, rest facility, nursing facility or facility for the aged.
- Furnishes primarily domiciliary or custodial care, including training in the routines of daily living.
- Operated primarily as a school.