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Anthem BCBS PPO Plus Option Summary of Coverage for Management Employees

Effective January 1, 2020

V-AM-A-M-88239-1/20

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Introduction to your medical coverage

This summary of coverage (SOC) document describes medical benefits under the Anthem Blue Cross Blue Shield (BCBS) preferred provider organization (PPO) Plus 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).

If you have questions, call Anthem BCBS at the number on your medical ID card.

The PPO Plus option is self-funded by Verizon Communications Inc. and administered by Anthem BCBS, the outside administrative organization. The benefits described in this SOC are effective as of January 1, 2020.

Accessing your benefits information

Your medical benefits are described in the following documents:

- This **PPO Plus option SOC**.
- The **medical SPD**.
- The **prescription program SOC**.

Your medical SPD and the SOCs for your medical option and prescription program are available online on BenefitsConnection. Generally, the documents on BenefitsConnection are the most up to date. Once you have logged onto BenefitsConnection, select the Library link from the home page to view "Summary Plan Descriptions."

For free printed copies of your SPD or SOCs, contact the Verizon Benefits Center at 855.4VzBens (855.489.2367).

Participating providers

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

- Accessing Anthem BCBS's website.
- Accessing BenefitsConnection.
- Calling Anthem BCBS directly.

For additional contact information, see the "Medical plan contacts" information that follows.

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Medical plan contacts

Option	Contact	Reasons to access
Preferred provider organization (PPO) Plus option		
For medical care	Anthem BCBS www.anthem.com **Member Services** 800.875.6139 **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 listing, free of charge. • Submit claims, if necessary. • Check the status of a claim. • Contact the BlueCare Consultant program through Member Services to: - Avoid denials if you need to provide notification or certification regarding Emergency Care, surgery, hospitalization or certain other procedures. - Self-refer to the BlueCare Consultant program. - Notify Anthem BCBS that a covered individual is pregnant. • Speak to a NurseLine℠ registered nurse

Option	Contact	Reasons to access
Other sources for information		
BenefitsConnection	Via the Internet at: www.verizon.com/benefitsconnection (User ID and password required) Via About You on the VzWeb	• Enroll for coverage. • Verify eligibility and coverage. • Review personal benefits information. • Make changes to your coverage due to a qualified life event. • Update dependent information. • Link to medical option Provider sites (online only). • Create and print personalized Provider listings. • Verify eligibility for COBRA coverage. • Enroll in COBRA coverage. • Notify Verizon of a COBRA qualifying event. • Update COBRA coverage due to a subsequent COBRA qualifying event. • Request an SPD or SOC.
Verizon Benefits Center	855.4VzBens (855.489.2367)	
Subrogation vendor	Equian, LLC Attention: Verizon Subrogation Unit P.O. Box 36380 Louisville, KY 40233 800.225.9695	

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How the PPO Plus option works

The PPO Plus option uses Anthem BCBS's BlueCard PPO network. Your benefits are based on whether you use Providers in your option's network. Check with your Provider to be sure he or she participates in the PPO network before you make your appointment to ensure you receive the highest level of benefits you are eligible to receive.

If you elect the PPO Plus option and you use a:

- PPO Provider, benefits are based on Network Negotiated Fees (NNF).
- Non-PPO provider, benefits are based on the actual charge, up to the Maximum Allowed Amount. You are responsible for paying any amount the option does not pay.

The charts in the "What is covered" section show how much the PPO Plus option pays.

Using the PPO network

A preferred provider organization (PPO) is a network of Health Care Providers who agree to meet strict quality standards and provide services according to a Network Negotiated Fee (NNF) Schedule. The NNF Schedule determines the maximum amount a Provider can charge.

Your Doctor (Physician), Hospital or other Health Care Provider already may participate in the Anthem BlueCard PPO network. See the "Participating providers" section for instructions on how to obtain the list of Providers.

When you use a PPO Provider, you must show your medical ID card to be billed at the PPO Network Negotiated Fee charge.

In general, there are no claim forms to fill out when you use a Participating Provider. Otherwise, you will need to complete a claim form. See the "Filing claims" section for additional information.

Covered services

The PPO Plus option pays benefits for covered services or supplies provided by licensed Health Care Providers, such as a Doctor or Physician, and related to an accidental Injury, Illness or pregnancy. The option also covers many preventive care services, as well as specific types of infertility treatments.

To be covered, a service, supply or expense must meet each of the following criteria. It must:

- Be medically necessary.
- Be dispensed by a licensed Health Care Provider.
- Be appropriate and required for the relevant diagnosis or treatment of an Illness, Injury or pregnancy.
- Follow accepted medical standards.
- Be the most appropriate, least intensive and most cost-effective alternative.

Anthem BCBS decides whether to cover new technologies, procedures and treatments based on the conclusions of medical research and peer-review studies.

Medically necessary

Medically necessary services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to

a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
- Not primarily for the convenience of the covered individual, physician or other health care Provider; and
- 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 covered individual's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. Determining medical necessity is a complex process that includes the application of Anthem BCBS'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-V (Diagnostic and Statistical Manual of Mental Disorders) mental or substance-related disorder provided by a mental health/substance abuse professional licensed to practice independently who meets Anthem BCBS's credentialing standards.

Annual deductible

If you participate in the PPO Plus option and use in-Network Providers, you do not pay a Deductible for many covered charges. If you participate in the PPO Plus option but use non-participating provider, you pay a Deductible before the plan covers most charges. However, a Deductible is not required for preventive care and certain other expenses under the PPO Plus option. Limited exceptions to these general rules are highlighted in this SOC.

The Deductible is $1,100 per individual and $3,300 per family:

- **Individual annual Deductible**. This is the amount each covered person pays during a calendar year for covered expenses that are subject to the annual Deductible.
- **Family annual Deductible**. The family annual Deductible is satisfied when any combination of individual family member Deductibles equals $3,300 within a calendar year. An individual will never satisfy more than his or her own individual amount. In general, once the family annual Deductible is met, a covered individual's eligible expenses are not subject to any further Deductible for the remainder of the calendar year, regardless of whether that individual has met his or her individual Deductible.

Expenses for covered services for several Illnesses or Injuries can be added together to meet the annual Deductible. After meeting the Deductible, a covered person is responsible for paying any applicable Coinsurance.

There are expenses that **do not** apply toward the annual Deductible. See the "What does not apply to annual deductibles and out-of-pocket maximums" section for more information.

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Coinsurance

Coinsurance is a percentage of the Network Negotiated Fee when a PPO Provider is used. If a PPO Provider is not used, your Coinsurance is a percentage of the amount charged up to the Maximum Allowed Amount.

The schedules of benefits contained in this SOC indicate the percentage that the PPO Plus option will pay on your behalf whether you use a PPO Provider or a non-participating provider. So, for example, if a particular service says 80% when a PPO Provider is used, you will pay 20% of the Network Negotiated Fee up to the annual out-of-pocket maximum. On the other hand, if a non-participating is used and the particular service says 60%, you will pay 40% of the Maximum Allowed Amount up to the annual out-of-pocket maximum.

Annual out-of-pocket maximum

The annual out-of-pocket maximum limits the amount each covered person pays each calendar year for covered services.

The out-of-pocket maximum is $2,200 per individual and $6,600 per family:

- **Individual annual out-of-pocket maximum**. Once a covered person reaches the annual out-of-pocket maximum, the PPO Plus option pays 100% of covered services for that person for the rest of the calendar year.
- **Family annual out-of-pocket maximum**. The family annual out-of-pocket maximum can be satisfied by any combination of family members within a calendar year. An individual will never satisfy more than his or her individual amount. When the family annual out-of-pocket maximum is met, the PPO Plus option pays 100% of all medically necessary covered services for all covered family members for the rest of that calendar year, regardless of whether an individual has met his or her individual out-of-pocket maximum.

The Deductible and Coinsurance amounts you pay each year are applied toward your annual out-of-pocket maximum, but some expenses do not apply. (See the “What does not apply to annual deductible and out-of-pocket maximums” section that follows for more information.)

Additional layer of protection for your share of in-network costs

As required by the Affordable Care Act, your total in-network out-of-pocket costs in 2020, including Copays and prescription drug expenses under the medical plan options available to you, will not exceed $7,150 for individual coverage and $14,300 for family coverage [subject to adjustments consistent with applicable law]. The individual in-network out-of-pocket maximum required by the Affordable Care Act applies to expenses incurred by each individual covered by the plan, regardless of whether the individual is covered under self-only coverage or other-than-self-only coverage (for example, family coverage). Your underlying medical plans out-of-pocket maximums remain unchanged, and Copays and prescription drug expenses will not apply toward such amounts.

Costs that apply toward your total in-network out-of-pocket maximum include, for example, Deductibles, Copayments, Coinsurance and as noted above, prescription drug expenses. (This plan option also has an underlying out-of-pocket expense maximum with separate requirements.) Examples of out-of-pocket expenses that do not apply toward meeting the out-of-pocket maximum “extra layer of protection” are premium contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand-name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your Physician.

What does not apply to annual deductibles and out-of-pocket maximums

Expenses that do not apply toward the annual Deductible or out-of-pocket maximum include:

- Any expense that is not considered a covered service.
- The portion of any covered service over the Maximum Allowed Amount.
- Any expenses incurred when Anthem BCBS is not notified as required.
- Expenses from enrollment in other Anthem BCBS plans.
- Copayments (Exception: Copayments ***do*** apply toward the additional layer of in-network, out-of-pocket cost protection as explained under an "Additional layer of protection for your share of in-network costs.").
- Charges above the lifetime maximum for infertility treatment.
- Charges that exceed any of the annual benefit, service or dollar maximums.
- Expenses for medications covered under the prescription drug program. (Exception: Prescription drug expenses ***do*** apply toward the additional layer of in-network, out-of-pocket protection as explained under "An additional layer of protection for your share of in-network costs".) See the prescription program SOC for more information. See the “Accessing your benefits information” section for information on how to access this document.
- Expenses for vision services and supplies covered under Verizon’s vision plan. See your vision SPD for details.

Recovery of Overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the Provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan’s third-party administrator. Under this process, the third-party administrator reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to Providers under this Plan are subject to this same process when the third-party administrator recovers overpayments for other plans administered by the third-party administrator. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

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Get Well, Stay Well, Be Well - your health management resources

Anthem BCBS 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 BCBS'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:
  - Chronic Condition Management.
  - MyHealth Notes (member communication).
  - Behavioral health support.
  - Health Pregnancy program (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.

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 will 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 (DME) - when possible, at least 15 days before purchasing or renting DME 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 nonemergency ambulance transport.

Pre-certification

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

Inpatient services requiring pre-certification

- Bariatric surgery
- Elective medical/surgical admissions
- Emergency medical/surgical admissions (require notification no later than 2 business days after admission)
- OB related Admissions (complications, excludes childbirth)
- Inpatient admissions for ALL organ and bone marrow/stem cell transplants
- Stem cell/Bone Marrow transplant (with or without myeloablative therapy)
- Heart transplant
- Liver transplant
- Lung or double lung transplant
- Simultaneous pancreas/kidney transplant
- Pancreas transplant

- Kidney transplant
- Small bowel transplant
- Multi-visceral transplant
- Long-term acute care facility
- Newborn stays beyond mother
- Skilled nursing facility
- Rehabilitations facility admission
- Mental health/substance abuse admissions

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

You must certify emergency Hospital admissions within two business days

Outpatient services requiring pre-certification

- Bariatric surgery
- Bone marrow and stem cell transplant
- Stem cell/bone marrow transplant (with or without myeloablative therapy)
- Dono leukocyte infusion
- Plastic/reconstructive surgeries (including, but not limited to the specific procedures listed)
  - Blepharoplasty
  - Rhinoplasty
  - Panniculectomy and lipectomy/diatasis recti repair
  - Insertion/injection of prosthetic material collagen implants
  - Chin implant/mentoplasty/osteoplasty mandible
  - Private duty nursing (home)
  - UPPP surgery (uvulopalatopharygoplasty - correction for sleep apnea)

Behavioral health services requiring pre-certification

- Inpatient behavioral health/Substance Abuse
- Residential care (RTC)

A.I.M. specialty health services

- Sleep therapy

Other

- DME/prosthetics/orthotics over $5,000
- Home health care (includes home infusion billed by HHC agency)
- Home infusion therapy (billed by home infusion specialist)
- Hospice
- Non-emergency ambulance or ambulette transport

Penalty for not calling

If you do not call your BlueCare Consultant when required, your claim will be denied as not covered if medical records have not been received. The claim may be re-opened if additional medical information is received at a later date. Any services deemed not medically necessary will be denied under the PPO Plus option.

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Chronic Condition Management

Anthem BCBS 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.
- Cancer.
- Chronic Obstructive Pulmonary Disorder (COPD).
- Congestive heart failure.
- Coronary artery disease.
- Depression.
- Diabetes.
- 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 the BlueCare Consultant program through Member Services.

MyHealth Notes (member communication)

Information can be an important tool for improving your health. As a part of your Anthem BCBS plan, technology is used to monitor your health information and look for improvement opportunities. The health information from Anthem BCBS 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: assistance during a crisis, 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.

Healthy Pregnancy program (maternity support)

Whether you are expecting a baby or just considering becoming pregnant, Anthem BCBS 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 healthy 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.

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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.

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 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

When the expense meets the definition of a covered service as explained in this SOC, the PPO Plus option covers the following services, supplies and expenses. Anthem BCBS is an independent organization with its own contract provisions, benefits and Network Providers. If you have questions about covered charges, you should contact Anthem BCBS. See the “Medical plan contacts” section for contact information.

- Preventive care services.
- Physician services, radiology and diagnostic laboratory tests.
- Hospitalization, inpatient surgery and outpatient surgery.
- Maternity care and family planning.
- Skilled nursing care, home health care and hospice care.
- Care received in a residential treatment center.
- 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.

Under the Affordable Care Act, the PPO Plus option must offer certain in-network preventive care items and services to you and your eligible dependents with no cost sharing (i.e., no Copayments, Coinsurance or Deductible).

In-Network preventive care items and services that must be provided without cost sharing change periodically. Information about what in-network preventive care items and services must be provided at no cost to you under the Affordable Care Act is available at **https://www.healthcare.gov/preventive-care-benefits/**.

In-network preventive care items and services with no cost sharing include a number of screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations, counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as a specialist consultation, bowel preparation medications, anesthesia, and polyp testing) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.

For women, the PPO Plus option also will cover in-network, with no cost sharing, an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods and counseling as prescribed for women; breastfeeding support (including lactation counseling services), supplies and counseling; and screening and counseling for interpersonal and domestic violence.

In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing and counseling and if at low risk for adverse medication effects may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your Doctor or Physician prescribes this type of medication to reduce your risk of breast cancer, contact Express Scripts to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be

required to meet requirements beyond just submitting the prescription. For example, you and/or your Physician may need to demonstrate that you are at an increased risk for breast cancer.

NOTE:

The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting and other limitations for a recommended preventive care service. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

If you have any questions regarding whether a particular preventive care item or service will be offered with no cost sharing, please contact Anthem.

Preventive care services

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO provider, the amount the option pays is based on the Maximum Allowed Amount.

Option provision	PPO Plus option Participating or non-participating provider (for preventive care services)
Deductible	**No**
Copayment	**No**
Annual maximum benefit per covered person	**No**
Service or treatment	
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: General medical exam, including: • Height and weight. • Medical history. • General health counseling. • Blood pressure. • Electrocardiogram (EKG). • Intradermal tuberculosis testing. • Lab tests (Hematocrit, CBC and SMAC). • Lipid profile, serum cholesterol. • Urinalysis.	

Option provision	PPO Plus option Participating or non-participating provider (for preventive care services)
Well-woman exams	
Includes Pap test and related lab fees	**100%**
Mammograms	**100%**
Immunizations and flu shots	**100%**
Prostate-specific antigen test	**100%**
Colonoscopy (colon cancer test)	**100%**
Sigmoidoscopy	**100%**
Fecal occult blood test	**100%**

Physician services, radiology and diagnostic laboratory tests

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO Provider, the amount the option pays is based on the Maximum Allowed Amount.

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
Primary care physician (PCP) or OB/GYN office visit for diagnosis and treatment of an Illness or Injury	**100%**, after $20 Copayment	**60%**, after Deductible
LiveHealth Online	$10 Copayment in network	
Specialist office visit	**100%**, after $35 Copayment	**60%**, after Deductible
Allergy testing and treatment	**100%**, $20 Copayment for PCP office visit/$35 Copayment for specialist office visit (Copayment is waived if office visit charge not made)	**60%**, after Deductible
Allergy injections	**100%**, after $20 Copayment for PCP office visit/$35 Copayment for specialist office visit (Copayment	**60%**, after Deductible

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
	is waived if office visit charge not made)	
Voluntary second surgical opinion	**100%**	**60%**, after Deductible
Outpatient radiology	**80%**, Outpatient radiological imaging services are not subject to the Deductible, but apply towards the out-of-pocket maximum	**60%,** after Deductible, but apply towards the out-of-pocket maximum
Diagnostic laboratory tests	**100%**, after $20 Copayment	**60%**, after Deductible, but apply towards the out-of-pocket maximum
Pre-admission tests		
• In a Physician's office	**100%**, after $20 PCP Copayment	**60%**, after Deductible
• In an outpatient facility	**80%,** no Deductible	**60%**, after Deductible
Chiropractic services		
Up to 20 visits per calendar year	**100%**, after $35 Copayment	**60%**, after Deductible

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

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO Provider, the amount the option pays is based on the Maximum Allowed Amount.

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
Hospitalization and inpatient surgery		
• Physician charges	**80%**, after Deductible	**60%**, after Deductible

Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
• Facility charges	**80%**, after Deductible	**60%**, after Deductible
• Physician-administered prescriptions	**80%**, after Deductible	**60%**, after Deductible

Coverage is provided for necessary Hospital charges for semiprivate room and board and related services and supplies. Other covered 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 PPO Plus option 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 PPO Plus option.
  - Surgery for temporomandibular joint (TMJ) disorder, but only if Anthem BCBS 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 radiology, lab and other diagnostic studies.
- Hospital private room charges above the most prevalent semiprivate room rate of that Hospital or Hospitals in the area.

To receive maximum benefits, call your BlueCare Consultant before being admitted to the Hospital if your Doctor recommends hospitalization.

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Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Sometimes a Hospital stay is not the most appropriate, cost-effective or comfortable way to receive medical care. The PPO Plus option may cover alternatives to a Hospital stay, such as a skilled nursing facility, home health care, hospice care and outpatient surgery, when appropriate.		
Human organ or tissue transplants		
• In a designated Blue Distinction Center for Transplant (BDCT) when applicable	**100%**, no Deductible	**60%**, after Deductible
• In other facilities	**80%**, after Deductible	**60%**, after Deductible

Human organ and tissue transplants are covered, subject to the following:

- If the recipient and identified donor both are covered persons under the PPO Plus option, benefits are provided for both parties.
- If the recipient is a covered person under the PPO Plus option, but the identified donor is not, benefits are provided for both individuals to the extent that benefits are not provided to the identified donor under any other plan.
- If the identified donor is a covered person under the PPO Plus option, but the recipient is not, benefits are provided to the identified donor for his or her expenses only. No benefits are provided to the recipient.
- Testing for potential donors is not covered.
- The National Donor Search maximum benefit allowance is $25,000.

When a transplant procedure is performed at a designated BDCT facility, the PPO option covers eligible charges for organ and tissue transplants at 100%. They also pay reasonable travel and accommodation expenses, subject to daily limits set by Anthem BCBS and not to exceed $10,000, for you and one companion (two companions if the patient is a minor). A $50 per day lodging maximum applies. Travel and lodging is only covered for BDCT facilities that are 75 miles or further from the patient's home.

Your Provider must pre-certify an organ transplant with your BlueCare Consultant for you to receive benefits. As soon as you are identified for a potential transplant procedure, please contact your BlueCare Consultant.

Exclusions

The PPO Plus option does not cover the following:

- Testing for potential donors.

Travel and lodging for a companion if the patient is not using a BDCT and if that center is not at least 75 miles away from the patient's home.

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Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Outpatient surgery		
Physician charges		
• In the office	**100%**, $20 Copayment for PCP/$35 Copayment for specialist; no Deductible	**60%**, after Deductible
• In a facility	**80%**, after Deductible	**60%**, after Deductible

The PPO Plus option pays for medically necessary outpatient surgery, including the cost of anesthesia, provided at an ambulatory surgical center, the outpatient department of a Hospital, a surgical day care center or your Doctor's office.

Multiple surgical procedures
If multiple procedures are performed during the same operation, the PPO Plus option pays separately for each procedure:

- The covered procedure with the highest cost is paid at the applicable Coinsurance level.
- For each additional covered procedure, the PPO Plus option pays 50% of what it otherwise would pay.

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 BCBS.	**100%**, after $200 Copayment per visit; Copayment waived if patient is admitted to the Hospital; no Deductible	**100%**, after $200 Copayment per visit; Copayment waived if patient is admitted to the Hospital; no Deductible
Non-emergency use of Emergency Care facilities	**Not covered**	**Not covered**
Urgent care		
Urgent care is covered for treatment of conditions or services provided that are non-preventive or non-routine 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 BCBS.	**100%**, after $50 Copayment per visit; no Deductible

100%, after $50 Copayment per visit; no Deductible

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Maternity care and family planning

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO provider, the amount the option pays is based on the Maximum Allowed Amount.

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

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
Physician office visit for prenatal care and the physician's associated delivery services	**100%**, after $20 Copayment for initial visit; no Deductible	**60%**, after Deductible
Facility charges	**80%**, after Deductible	**60%**, after Deductible

- 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 feels the Hospital stay for the mother and/or her newborn needs to be extended, you must call 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. See “Your maternity rights (Newborns’ and Mothers’ Health Protection Act)” in your medical 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	**80%**, after Deductible	**60%**, after Deductible

- Services of a freestanding birthing center, including room and board, medical services and supplies, and anesthetics and their administration. A birthing center is a facility for the delivery of Children following a normal, uncomplicated pregnancy. Patients are expected to be discharged or transferred within 24 hours after delivery. To qualify, the facility must meet the following requirements:
  - Is licensed in the state where it is located, if required.
  - Operates according to state laws.
  - Is equipped to perform routine diagnostic exams.
  - Has the staff and equipment to handle foreseeable emergencies.
  - Is operated under the supervision of a Doctor (M.D.) or registered nurse (R.N.).
  - Has an agreement with a nearby hospital for the immediate transfer of patients who develop complications.
  - Maintains adequate medical records.

- Birthing centers that are part of hospitals will be treated as birthing centers under the PPO Plus option.

Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Nurse-midwife services	**80%**, after Deductible	**60%**, after Deductible
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	**50%**, after Deductible	**50%**, after Deductible
Coverage includes artificial insemination, subject to a $20,000 lifetime maximum, combined with pharmacy. **NOTE:** Diagnosis and treatment of underlying cause of infertility is covered at the office visit Copayment or at the 80% or 60% Coinsurance level based on use of in- or out-of-network Providers. • Artificial insemination, in-vitro fertilization, GIFT , and ZIFT are covered 50% after deductible, in- and out-of-network, subject to a $20,000 lifetime maximum. Lifetime maximum is combined with pharmacy. Services are covered regardless of diagnosis. • Cryopreservation is covered with the following limitations, after Deductible and subject to the $20,000 lifetime maximum: - Cryopreservation of embryos (e.g. in conjunction with In-vitro fertilization) is covered 50% after Deductible, in- and out-of-network, subject to the $20,000 lifetime maximum. ▪ Storage is covered at 100% after Deductible for the first year and 50% Coinsurance after Deductible in subsequent years. - Cryopreservation of eggs/oocytes (to delay child-bearing) is covered once per lifetime. Deductible and 50% Coinsurance apply, subject to the $20,000 lifetime maximum. ▪ Storage is covered at 50% Coinsurance after Deductible for one year. 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 without a waiting period or Doctor's approval. See "Hospitalization, inpatient surgery and outpatient surgery." **NOTE:** **Reversals of voluntary sterilization procedures are not covered.**		

Skilled nursing care, home health care and hospice care

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO Provider - the amount the option pays is based on the Maximum Allowed Amount.

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**
Skilled nursing care Up to 120 days per calendar year; combined in- and out-of-network.	**100%**	**60%**, after Deductible

There sometimes is a need for intermediate care following a hospital stay. While you may no longer 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 PPO Plus option 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 one 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 a licensed practical nurse (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 one 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.

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**
• 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. 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 care.		
Outpatient private duty nursing and home health care when provided as part of home health care benefit		
Up to 120 days per calendar year; combined in- and out-of-network. Home IV therapy visits do not count towards the maximum.	**100%**	**60%**, after Deductible
Home health care is part-time or intermittent nursing care by an R.N., L.P.N. or a qualified home health aide under the supervision of an R.N.		
The PPO Plus option covers outpatient private duty nursing by an R.N. or L.P.N. or a nursing agency for private duty nursing care when the person’s condition requires skilled nursing services and visiting nursing care is not adequate. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. 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.		
In addition, the PPO Plus option covers home health care treatment ordered and supervised by your Doctor. Treatment must be provided by a home health care agency including part-time or intermittent nursing care (or care by a qualified home health aide) by or under the supervision of an R.N. A home health care agency must meet the following requirements: • 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 one physician and one R.N.		

Exclusions

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**

- That part or all of any nursing care that does not require the education, training and technical skills of an 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 one 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 an R.N. or L.P.N.
- Home health care services for Custodial Care or any time period that you are not under the care of a Doctor.

To be eligible for private duty nursing home health care benefits, call your BlueCare Consultant before receiving care.

Hospice care	**100%**	**60%**, after Deductible

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 Anthem BCBS 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 PPO Plus option 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.

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**
• 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.		

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**
Exclusions • Funeral expenses. • Pastoral counseling. • Financial or legal counseling. This includes estate planning and the drafting of a will. • Homemaker or caretaker services, other than respite care subject to the limits specified above. These are services that are not solely related to the care of the person. Such services include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.		

Other services

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO Provider, the amount the option pays is based on the Maximum Allowed Amount.

Service or treatment	**PPO Plus option**	
	PPO provider	**Non-PPO provider**
Medical services and supplies	**80%**, after Deductible	**60%**, after Deductible
The PPO Plus option pays for the following: • Office visits for prescription of smoking cessation drugs. • Blood and blood plasma. • Oxygen and its administration, including the rental of required equipment. Contact your BlueCare Consultant if a durable medical equipment purchase will exceed $5,000. Prescription drugs are managed separately under the prescription program. See your prescription program SOC for more information.		
Retail health clinics		
Retail health clinics may be best for treatment of minor Illnesses and some preventive health care services, such as flu shots and	physicals.	**100%,** after $20 Copayment per visit, no Deductible

100%, after $20 Copayment per visit, no Deductible

	PPO Plus option	
Service or treatment	**PPO provider**	**Non-PPO provider**

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Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Physical therapy		
Limited to 60 visits per calendar year (combined in- and out-of-network with occupational therapy - for all conditions other than the ones listed below).		
• Provider charges	**100%**, after $35 Copayment; no Deductible	**60%**, after Deductible
• Facility charges	**80%**, after Deductible	**60%**, after Deductible

Coverage is provided only for rehabilitation services that are expected to result in documented, measurable progress in return to function.

The following conditions have a combined therapy maximum of 60 days per calendar year for physical, occupational, speech and cognitive therapies and are covered through age 6 only:

- Development delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.
- Physical therapy, occupational therapy and speech therapy for the following diagnosis over the age of 6, should be covered based on medical necessity under the standard 60 visit therapy limit:
  - Development delay or cerebral palsy.
  - Hearing impairment.
  - Major Congenital Anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

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. Inpatient rehabilitation therapy is medically necessary for covered persons whose complex physical/medical condition requires 24-hour availability of Physician and nurses.

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.

Physical therapy

Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Occupational therapy		
Limited to 60 visits per calendar year combined in- and out-of-network with physical therapy (for all conditions other than the ones listed below).		
• Provider charges	**100%**, after $35 Copayment; no Deductible	**60%**, after Deductible
• Facility charges	**80%,** after Deductible	**60%**, after Deductible
Coverage is provided only for rehabilitation services that are expected to result in documented, measurable progress in return to function.		
The following conditions have a combined therapy maximum of 60 days per calendar year for physical, occupational, speech and cognitive therapies and are covered through age 6 only:		
• Development delay or cerebral palsy. • Hearing impairment. • Major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate. • Physical therapy, occupational therapy and speech therapy for the following diagnosis over the age of 6, should be covered based on medical necessity under the standard 60 visit therapy limit: - Development delay or cerebral palsy. - Hearing impairment. - Major Congenital Anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.		
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. Inpatient rehabilitation therapy is medically necessary for covered persons whose complex physical/medical condition requires 24-hour availability of Physician and nurses.		
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.		

Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Speech therapy		
Limited to 45 visits per calendar year in- and out-of-network not combined with any other therapy (for all conditions other than the ones listed below)		
• Provider charges	**100%**, after $35 Copayment; no Deductible	**60%**, after Deductible
• Facility charges	**80%**, after Deductible	**60%**, after Deductible

Speech therapy benefits are available only for rehabilitation services that result in documented and measurable progress in return to function. Coverage for speech therapy is provided when the speech impediment or dysfunction results from Injury, sickness, stroke, cancer, or a congenital anomaly or if needed following the placement of a cochlear implant.

The following conditions have a combined therapy maximum of 60 days per calendar year for , physical, occupational, speech and cognitive therapies and are covered through age 6 only:

- Development delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.
- Physical therapy, occupational therapy and speech therapy for the following diagnosis over the age of 6, should be covered based on medical necessity under the standard 60 visit therapy limit:
  - Development delay or cerebral palsy.
  - Hearing impairment.
  - Major Congenital Anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

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.

Autism Spectrum Disorder (ASD)		
Applied Behavioral Analysis (ABA) therapy is covered with no visit or age limits for a diagnosis of Autism Spectrum Disorder. Physical, Occupational and Speech Therapy covered with no visit or age limits for a diagnosis of Autism Spectrum Disorder.		
Provider charges	**100%**, after $20 Copay for PCP office visit/$35 Copayment for specialist office visit; no Deductible	**60%**, after Deductible
Facility charges	**80%**, after Deductible	**60%**, after Deductible

- Services will need to be Medically Necessary

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
- Supported by national medical standards of practice. - Consistent with medical research that concludes the service has a beneficial effect on health outcomes, based on testing and studies. • In most cases, a service or supply that is not medically necessary is not covered, even if it is ordered by a Doctor. • Verizon shall provide coverage for services to a member enrolled in the health plan who has a primary verified diagnosis of autism spectrum disorder: A diagnosis of ASD has been made by a licensed medical professional or other qualified Health Care Professional. • Anthem will require the treating Provider compile a treatment plan, and will manage benefits frequently, so that the right benefits are delivered to the right member at the right time. • Nothing in this benefit coverage shall be construed as requiring Verizon or its health plan carrier to provide benefits for services that are or should be included in an individualized family service plan, an individualized education program, an individualized service plan, or other publicly funded programs, including but not limited to reimbursement for services provided at private schools. Services may be provided by a licensed therapist certified for ABA treatment or an unlicensed therapist certified for ABA treatment under the supervision of a licensed certified Provider. Predetermination is recommended. ABA therapy requires review for medical necessity.		
Emergency ambulance service	**80%**, after Deductible	**80%**, after Deductible
Coverage is provided for professional ground ambulance/ambulette to and from a hospital or other medical facility for emergency services. If emergency treatment is not available locally, the PPO Plus option also covers the cost of a regularly scheduled air ambulance, plane or train to the nearest Hospital qualified to give treatment. Transportation must be within the continental United States, Alaska, Hawaii, Puerto Rico or Canada. Contact your BlueCare Consultant for requests involving non-emergency transport. Non-emergency transport requires pre-certification.		
Durable medical equipment	**80%**, after Deductible	**60%**, after Deductible
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. Anthem BCBS determines whether an item is eligible for rental or purchase. Deluxe wheelchairs are covered up to the allowance of the base model.		
Prosthetics	**80%**	**60%**
Artificial limbs or eyes and other appliances are covered for the replacement of a body organ or part. The PPO Plus option 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.		

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
At Anthem BCBS's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear when repair costs are less than the cost of replacement or when a change in the individual's medical condition occurs. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. Pre-certification is required for items over $5,000.		
Exclusions Replacement appliances due to wear and tear that have been in use less than 3 years, unless repairing a damaged appliance that is not serviceable is more expensive than replacing it.		
Wigs		
Wigs are limited to one per calendar year. Subject to medical necessity.	**80%**, after Deductible	**60%**, after Deductible
Hearing aids and supplies	**80%**, after Deductible	**60%**, after Deductible
Coverage is provided for: • Children age 12 and under up to a maximum of $1,000 per year for medical necessity. • Over age 12 up to a maximum of $1,000 per year every 24 months. No coverage is provided for breakage or loss of devices. No coverage is provided for progressive hearing loss due to the aging process.		
Cochlear implants	**80%**, after Deductible	**60%**, after Deductible

Service or treatment	PPO Plus option	
	PPO provider	**Non-PPO provider**
Acupuncture services	**100%**, after $20 Copayment for PCP office visit/$35 Copayment for specialist office visit; no Deductible	**60%**, after Deductible

The PPO Plus option covers up to a maximum of 20 visits during a calendar year, combined in- and out-of-network, for acupuncture treatment by an M.D., D.O., D.C. or acupuncturist licensed by the state or certified by the National Commission of Acupuncturists/OMD. 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.

Radiation therapy		
• In a Physician's office	**100%**, $35 Copayment for specialist; no Deductible	**60%**, after Deductible
• In a Hospital	**80%**, after Deductible	**60%**, after Deductible
Chemotherapy		
• In a Physician’s office	**100%**, $35 Copayment for specialist; no Deductible	**60%**, after Deductible
• In a Hospital	**80%**, after Deductible	**60%**, after Deductible
Reconstructive surgery	**80%**, after Deductible	**60%**, after Deductible

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 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.

Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
Oral surgery		
• In a Physician's office	**100%**, $35 Copayment for specialist; no Deductible	**60%**, after Deductible
• In a facility	**80%**, after Deductible	**60%**, after Deductible

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 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 medical plan for review.

Treatment of TMJ dysfunction		
• In a Physician's office	**100%**, $35 Copayment for specialist; no Deductible	**60%**, after Deductible
• In a facility	**80%**, after Deductible	**60%**, after Deductible

Coverage includes exams, radiology, injections, anesthetics, physical therapy, oral surgery and supplies. TMJ appliances are covered by Anthem BCBS once benefits have been exhausted by your dental plan.

Exclusions
Tooth reconstruction or any treatment that is not medical in nature.

Vision services	Services, if performed in an office setting are to be paid at 100% after Copayment. If not, then in-network 80%, after Deductible.	**60%**, after Deductible

In-network routine vision screenings/exams are covered in full, no Copay. Vision services for the treatment of disease or Injury to the eye are covered. Vision services performed in an office setting are to be paid at 100% after applicable Copayment. All other places of service are covered. Out-of-network vision services covered at 60% subject to Deductible.

Service or treatment	PPO Plus option	
	PPO provider	Non-PPO provider
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 conventional monofocal intraocular lens.		
Nutritional counseling	Services, if performed in an office setting are to be paid at 100% after Copayment. If not, then in-network 80%, after Deductible.	**60%**, after Deductible
Nutritional counseling is covered for the following: • Diabetes and diabetes with associated co-morbidities. • Chemotherapy, with documented nutritional concerns (e.g., inability to tolerate oral intake, BMI [Body Mass Index] under 18). • BMI over 35 with significant associated co-morbidities. • BMI under 18, in association with behavioral health services. • Attempting to wean from feeding tubes. • Documented malabsorption disorders. • HIV positive with active disease. Nutritional counseling is limited to four visits for the list above. • Diagnosis of eating disorder is covered with no visit limits.		
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.		

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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 BCBS.
- Care, treatment, services or supplies that are not prescribed, recommended and approved by your attending Physician.
- 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 health care 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).
  - 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 claims 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 BCBS. 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 radiology and laboratory and machine tests not consistent with the diagnosis, symptoms or Illness.
- Athletic club dues or exercise equipment for the home.
- Reversal of a sterilization procedure.
- Services or supplies that are not necessary, as determined by Anthem BCBS, 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 BCBS determines are educational or developmental services or supplies, or for education or job training.
- Except in special circumstances as determined by Anthem BCBS, 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 BCBS.
- 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 treatment coverage" section.
- Services or supplies determined by the claims administrator to be for Experimental or Investigational purposes, including drugs or other care, as described in the "Terms to know" section of this SOC.
- Services paid under Medicare or which would have been paid if the member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B.
- Service for Hospital confinement primarily for diagnostic studies.
- Services and supplies (other than office visits for prescription of smoking cessation drugs) for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco or tobacco products.
- Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or prescriptions or medications related to hair growth.
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
- Christian Science Practitioner.
- Separate charges by interns, residents, house physicians or other health care professionals who are employed by the covered facility, which makes their services available.
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission.
- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

- Contraceptive drugs, except for any stated covered contraceptive services.
- Facility fees for surgery performed in a Provider's office.
- Administrative charges - charges for any of the following: failure to keep a scheduled visit, completion of claim forms or medical records or reports unless otherwise required by law; for physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results; specific medical reports including those not directly related to the treatment of the participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

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 BCBS.
- 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.
- Formula for infants if readily available over the counter, even if ordered by a Physician.
- Hand rails.
- Heating pads.
- Heating units for swimming pools.
- Herbal medicine or holistic or homeopathic care, including drugs.
- Home/vehicle modifications, including stair lifts and ramps.
- Humidifiers.
- Hypo-allergenic cosmetics or toiletries.
- Ice bags.
- Mattresses, except when purchased with a Hospital bed.
- Niagra vibrators.
- Overbed tables.
- Puritron air fresheners.
- Scales (weight).
- Telephones.
- Thermometers.
- Vaporizers.
- Walking canes with seat.
- Wig styling.

Other exclusions

- Charges that are more than the maximum allowed amount or the network negotiated fee,or in excess of any applicable annual maximum, as determined by Anthem BCBS.
- 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.

  NOTE:

  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 BCBS, due to an accidental injury, a 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.
- 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 Plan has the right to recover or place a lien on any benefits paid or payable if Workers’ Compensation provides benefits for the same condition.

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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 BCBS's Behavioral Health program. Verizon's Mental Health and Substance Abuse benefits are administered in compliance with the Mental Health Parity and Addiction Equity Act of 2008, including applicable regulatory and sub-regulatory guidance.

Medically necessary

Medically necessary services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
- Not primarily for the convenience of the covered individual, physician or other health care Provider; and
- 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 covered individual's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. Determining medical necessity is a complex process that includes the application of Anthem BCBS'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-V (Diagnostic and Statistical Manual of Mental Disorders) mental or substance-related disorder provided by a mental health/substance abuse professional licensed to practice independently who meets Anthem BCBS's credentialing standards.

How Anthem BCBS's Behavioral Health program works

Anthem BCBS provides treatment through a network of licensed psychiatrists, therapists, treatment centers and Hospital that must meet strict membership requirements. Anthem BCBS 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.

You also can receive treatment from out-of-network Providers. If you do, your costs generally will be higher.

What is covered under mental health and substance abuse treatment

Anthem BCBS 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 BCBS 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 two business days, you, a family member or a representative of the facility must contact Anthem BCBS to certify care. Anthem BCBS will determine if benefits are payable.

Outpatient treatment does not require pre-certification, however we recommend that you contact Anthem BCBS's Behavioral Health Resource Center using the phone number listed on the back of your 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 BCBS determines that an inpatient stay is required, it is covered on a semiprivate room (a room with two or more beds) basis.

If you use a PPO Provider, the amount the option pays is based on Network Negotiated Fees. If you do not use a PPO provider, the amount the option pays is based on the Maximum Allowed Amount.

Covered mental health and substance abuse treatment	**PPO Plus option**	
	PPO provider	**Non-PPO provider**
Inpatient Hospital treatment	**80%**, after Deductible	**60%**, after Deductible
Outpatient treatment	**100%**, after $20 Copayment per office visit	**60%**, after Deductible
Partial Hospitalization	**80%**, after Deductible	**60%**, after Deductible

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.

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How medical 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.

Mental Health and Substance Abuse treatment coverage is considered medical coverage for purposes of the Deductible and out-of-pocket maximum. For example, expenses for covered services that are for Mental Health or Substance Abuse treatment will be added with covered services for medical/surgical benefits for purposes of meeting your Deductible and/or out-of-pocket maximum however; Copayments and any costs not covered by Anthem BCBS do not apply to your annual Deductible and out-of-pocket maximum. For more information on expenses that **do not apply** toward the annual Deductible or out-of-pocket maximum, see the "What does not apply to annual deductibles and out-of-pocket maximums" section.

What is not covered

The following services and supplies are not covered under the Mental Health and Substance Abuse treatment program:

- For out-of-network services, any charges in excess of the Maximum Allowed Amount as determined by Anthem BCBS.
- 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-V diagnosis.
- Mental and psychoneurotic disorders not listed in the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-10).
- Court-mandated or legally mandated treatment that is not considered medically necessary, as determined by Anthem BCBS, or that would not otherwise be covered.
- Services or supplies that are determined by Anthem BCBS not to be medically necessary, including any confinement or treatment given in connection with a service or supply that is not medically necessary.
- Services or supplies you receive before you became covered under a PPO Plus option.

- Educational services for any of the following diagnoses: mental retardation (except the initial diagnosis), autism, pervasive developmental disorders, chronic organic brain syndrome, learning disabilities or transsexualism, except as expressly provided under "Covered services".
- 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-medically 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.
- 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.

NOTE:

Nothing in the PPO Plus option shall be construed to cover benefits for Mental Health, alcohol and Substance Abuse services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the Office of Children and Family Services; solely because such services are ordered by a court; that are cosmetic in nature on the grounds that changing or improving an individual’s appearance is justified by the individual’s

Mental Health needs; that are Experimental or Investigational treatments; or that are otherwise excluded under your contract, certificate, or the Group Health Plan, as outlined in your medical SPD.

Filing claims

When you receive care from PPO Network Providers, you do not have to file claims. PPO Providers will submit claims on your behalf.

If you receive care from a Provider who is not in the PPO network, you will need to file a claim and send copies of your bills and receipts to Anthem BCBS. See the “Medical plan contacts” section for contact information.

If your claim is denied, you have a right to appeal. See the “Filing an ERISA claim or appeal” section in your medical SPD for information on filing an appeal. See the “Accessing your benefits information” section for information on how to access this document.

Assignment

The claims administrator is authorized on behalf of Verizon to make payments directly to health care providers for covered services. The claims administrator also reserves the right to make payments directly to you, the participant. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person’s custodial parent or designated representative. Any payments made by the claims administrator will discharge the plan’s obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as required by a “Qualified Medical Child Support Order” as defined by ERISA or any applicable state or federal law. Once a health care Provider performs a covered service, the claims administrator will not honor a request to withhold payment of the claims submitted. The coverage and any benefits under the plan are not assignable by any covered member without the written consent of the plan, except as provided above.

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Terms to know

Affordable Care Act

In March of 2010, Congress passed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. These laws are commonly referred to as "Health Care Reform." For purposes of this SPD, they are collectively referred to as the "Affordable Care Act."

Anti-assignment

The claims administrator is authorized on behalf of Verizon to make payments directly to health care providers for covered services. The claims administrator also reserves the right to make payments directly to you, the employee. Payments may also be made, and notice regarding the receipt and/or adjudication of claims, to an alternate recipient, or that person's custodial parent or designated representative. Any payments made by the claims administrator will discharge the plan's obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state or federal law. Once a health care provider performs a covered service, the claims administrator will not honor a request to withhold payment of the claims submitted. The coverage and any benefits under the plan are not assignable by any covered person without the written consent of the plan, except as provided above.

BlueCare Consultant

A dedicated clinical contact at Anthem BCBS 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.

Child or Children

Your medical SPD, as updated in some cases, by a summary of material modification (SMM), contains the definition of an eligible dependent, including the definition of Child for medical plan purposes.

Coinsurance

A percentage of the Network Negotiated Fee when a PPO provider is used. If a PPO provider is not used, your coinsurance is a percentage of the amount charged up to the Maximum Allowed Amount.

Copayment (Copay)

A flat fee that you pay directly to the provider at the time of service.

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.

Deductible

The annual Deductible is the amount you pay each year before the plan begins paying benefits.

Doctor or Physician

The definition of Doctor or Physician 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.) acting within the scope of his or her license.

Emergency Care

Emergency Care is immediate medical treatment when the lack of treatment could reasonably be expected to place a patient's health in serious jeopardy, seriously impair a bodily function or cause a serious dysfunction of a bodily organ or part. Emergency Care also includes immediate Mental Health Treatment when the lack of treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Medical Care

Medically necessary services, procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's Illness, Injury or disease; and
- Not primarily for the convenience of the covered individual, Physician or other Health Care Provider; and
- 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 covered individual's Illness, Injury or Disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Hospital

A Hospital is a facility that is licensed as a Hospital and 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.
- Nursing care 24 hours a day.

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Illness

An Illness is a bodily disorder or disease, including a Mental Health Disorder or Substance Abuse.

Injury

An Injury is an accidental physical Injury to the body caused by unexpected external means.

Maximum Allowed Amount (MAA)

Maximum allowed amount (MAA)
This section describes how Anthem determines the amount of reimbursement for covered services. Reimbursement for services rendered by network/participating and out-of-network/non-participating providers is based on the medical plan's maximum allowed amount for the covered service that you receive.

The maximum allowed amount for the medical plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- That meet Anthem's definition of covered services, to the extent such services and supplies are covered under the medical plan and are not excluded;
- That are medically necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the medical plan.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your deductible or have a co-pay or co-insurance. In addition,when you receive covered services from an out-of-network/non-participating provider,you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant.

Example:

Assuming coverage under the PPO Plus option, here is an example of how benefits are paid depending on whether an in-network or out-of -network provider issued:

	Non-participating provider	**Participating provider**
Provider charge	$30,000	$30,000
Covered charge	$1,862 (maximum allowed amount)	$1,330 (network negotiated fee)
Difference between provider charge and covered charge (You pay)	$28,138	N/A
Annual deductible (You pay)	$1,100	$1,100
Covered charge less deductible	$762	$230
Plan coinsurance payment	$457.20 (60% x $762)	$184.00 (80% x $230)
Member coinsurance (You pay)	$304.80 (40% x $762)	$46.00 (20% x $230)

Total amount you pay	$29,542.80 (Difference between the provider charge and the covered charge, plus deductible and coinsurance)	$1,146.00 (Deductible and coinsurance)

When you receive covered services from a provider, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Anthem's determination of the maximum allowed amount. Anthem's application of these rules does not mean that the covered services you received were not medically necessary. It means Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the medical plan may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100% of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider network status
The maximum allowed amount may vary depending upon whether the provider is a network/participating provider or an out-of-network/non-participating provider.

A network provider or participating provider is a provider who is in the managed network for the medical plan or in a special center of excellence/or other closely managed specialty network, or who has a participation contract with Anthem. For covered services performed by a network provider or participating provider, the maximum allowed amount for the medical plan is the rate the provider has agreed with Anthem to accept as reimbursement for the covered services. Because network providers and participating providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your deductible or have a co-pay or co-insurance. You may call member services for help in finding a network provider or participating provider. See the"Medical plan contacts" section for contact information.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are out-of-network/non-participating providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For covered services you receive from an out-of-network/non-participating provider, the maximum allowed amount for the medical plan will be one of the following as determined by Anthem:

1. An amount based on Anthem's non-participating provider fee schedule/rate, which Anthem has established in their discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the CMS. When basing the maximum allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment, (2) level of skill and experience required for the treatment, or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by Anthem or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the non-participating provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered non-participating. For the medical plan, the maximum allowed amount for services from these providers will be one of the five methods shown above unless the contract between Anthem and that provider specifies a different amount.

For services rendered outside Anthem's service area by out-of-network/non-participating providers, the maximum allowed amount may be determined by using the local BCBS plan's non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or federal law. In certain situations, the maximum allowed amount for out of area claims may be based on billed charges, the pricing Anthem would use if the healthcare services had been obtained within the Anthem service area, or a special negotiated price.

Unlike network providers or participating providers, out-of-network or non-participating providers may send you a bill and collect for the amount of the provider's charge that exceeds Anthem'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.

Member Service can assist you in determining the medical plan's maximum allowed amount for a particular service from an out-of-network/non-participating provider. In order for Anthem to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out of pocket responsibility. Although Member Service can assist you with this pre-service information; the final maximum allowed amount for your claim will be based on the actual claim submitted by the provider.

Member cost share
For certain covered services and depending on the medical plan design, you may be required to pay a part of the maximum allowed amount as your cost share amount (for example,deductible,copayment, and/or coinsurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you receive services from a network/participating or out-of-network/non-participating provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using

out-of-network/non-participating providers. For cost share responsibilities and limitations on the medical option in which you enroll, refer to the SOC for that option, or contact member services. Refer to the "Accessing your benefits information" section for information on how to access the SOC for your option. See the "Medical plan contacts" section for contact information. Anthem will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a participating or non-participating provider. Non-covered services include services specifically excluded from coverage

by the terms of your medical plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your lifetime maximum, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower network cost sharing amount when you use an out-of-network/non-participating provider. For example, if you go to a network/participating hospital or provider facility and receive covered services from an out-of-network/non-participating provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a network hospital or facility, you will pay the network cost share amounts for those covered services. However, you also may be liable for the difference between the maximum allowed amount and the out-of-network/non-participating provider's charge.

Example: The medical plan has a coinsurance cost share of 20% for in-network services, and 40% out-of-network after the in- or out-of-network deductible has been met.

- *You choose a network or participating provider. The charge was $2,500. The maximum allowed amount for the service is $1,500; Your coinsurance responsibility when a Network provider issued is 20% o f$1,500, or $300. Anthem allows 80% of $1,500, or $1,200. The network provider accepts the total of $1,500 as reimbursement for the service regardless of the charges. Your total out of pocket responsibility would be $300.*
- *You choose an out-of-network/non-participating provider. The out-of-network non-participating provider's charge for the service is $2,500. The maximum allowed amount for the service is $1,500; Your coinsurance responsibility for the out-of-network or non-participating provider is 40% of $1,500, or $600 after the out-of-network deductible has been met. Anthem allows the remaining 60% of $1,500,or $900.* ***In addition****,the out-of-network non-participating provider could bill you the difference between $2,500 and $1,500, so your total out of pocket charge would be $600 plus an additional $1,000, for a total of* ***$1,600****.*

Authorized services
In some circumstances, such as where there is no network provider or participating provider available for the covered service, Anthem may authorize the network cost share amounts (deductible,copayment, and/or coinsurance) to apply to a claim for a covered service you receive from an *out-of-network or non-participating* provider. In such circumstance, you must contact Anthem in advance of obtaining the covered service. Anthem also may authorize the network cost share amounts to apply to a claim for covered services if you receive emergency services from an out-of-network/non-participating provider and are not able to contact Anthem until after the covered service is rendered. If Anthem authorizes a network cost share amount to apply to a covered service received from an out-of-network non-participating provider,you also may still be liable for the difference between the maximum allowed amount and the out-of-network/non-participating provider's charge. Contact member services for authorized services information or to request authorization. See the "Medical plan contacts" section for contact information.

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 [Fifth Edition-Text Revision] by the American Psychiatric Association [DSM-V-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 PPO Plus 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 precertification and is also subject to review for medical necessity according to Anthem BCBS medical policy. This surgery is considered medically necessary when the member meets Anthem BCBS 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.

Network Negotiated Fee (NNF) Schedule

The NNF Schedule determines the maximum amount a network provider will charge.

Participating PPO or Network Providers

A Provider or Health Care Provider that participates in the BlueCard PPO network.

Substance Abuse

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