WELLS FARGO

Summary Plan Description

Anthem Blue Cross Blue Shield PPO Plan

Effective January 1, 2010

Anthem Blue Cross Blue Shield PPO Plan

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Contacts

Questions	The claims administrator's customer service staff is available to answer your questions about coverage and direct your calls for preadmission and emergency admission notification. Monday – Friday: 7:00 a.m. – 7:00 p.m. Central Time
Customer service telephone number	Claims administrator: 1-866-418-7749
Anthem Blue Cross Blue Shield website	www.anthem.com Use this website to locate providers who participate with Blue Cross and Blue Shield plans nationwide, check out claim information and health programs or email customer service.
Information about premiums for the Anthem Blue Cross Blue Shield PPO Plan	Check your enrollment materials, or go to *Teamworks*.
Coverage while traveling number	1-800-810-BLUE (2583) Use this number to locate BlueCard PPO providers nationwide. For the highest level of benefits, you must use a BlueCard PPO provider.
Claims administrator's mailing address	Claims review requests and written inquiries may be mailed to the address below: Anthem Blue Cross Blue Shield PO Box 37110 Louisville, KY 40233 Prior authorization requests should be mailed to the following address: Anthem UM Services, Inc. PO Box 7101 Indianapolis, IN 46207
Pharmacy information	CVS Caremark 1-800-772-2301 www.caremark.com *Please note: When accessing prescription drug benefits, you must use your CVS Caremark ID card.*
24/7 NurseLine	1-866-220-4849 Members can receive one-on-one counseling with experienced Anthem nurses.
Information about mental health or substance abuse	OptumHealth Behavioral Solutions 1-800-720-4158 www.liveandworkwell.com (access code: **wellsfargo**)
Employee Assistance Consulting (EAC)	1-888-327-0027 TDD 1-877-411-0826

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Chapter 1

Administrative Information

The Basics

This Summary Plan Description (SPD) covers the provisions of the Anthem Blue Cross Blue Shield PPO Plan (the Plan).

While reading this material, be aware that:

- The Plan is a welfare benefits plan provided as a benefit to eligible team members and retirees and their eligible dependents. Participation in this Plan does not constitute a guarantee or contract of employment with Wells Fargo & Company or its subsidiaries. Plan benefits depend on continued eligibility.
- The name "Wells Fargo," as used throughout this document, refers to Wells Fargo & Company and each subsidiary that participates in the Plan. For your purposes, "Wells Fargo" means the legal entity that employs you.

In case of any conflict between the SPD, any other information provided, and the official Plan document, the Plan document governs Plan administration and benefit decisions. You may request a copy of the official Plan document by submitting a written request to the address below, or you may view the document on-site during regular business hours by prior arrangement:

Compensation and Benefits Department
Wells Fargo
MAC N9311-170
625 Marquette Avenue
Minneapolis, MN 55479

Wells Fargo contracts with third-party administrators to provide claims administrative services. These third-party administrators are referred to as claims administrators. The relationship of the health care providers and third-party administrators to Wells Fargo is that of independent contractors. This means that Wells Fargo cannot guarantee the quality of services rendered by the administrator.

While the Plan's provisions determine what services and supplies are eligible for benefits, you and your health care provider have ultimate responsibility for determining appropriate treatment and care.

Responsibilities of covered persons

Each covered team member or retiree and covered dependent is responsible for reading this SPD and related materials completely and complying with all rules and Plan provisions.

Definition of a Summary Plan Description (SPD)

An SPD explains your benefits and rights under the Plan. Your full SPD includes this booklet and the first two chapters and the appendixes of your *Benefits Book*. The *Benefits Book* and SPDs are available at *Teamworks* > Team Member Resources and at wellsfargo.com/teamworks. Every attempt has been made to make the *Benefits Book* and SPDs easy to understand, informative, and as accurate as possible. However, an SPD cannot replace or change any provision of the actual Plan documents.

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For a list of specific rights, review the section "Your Rights Under ERISA" in "Appendix B: Legal Notifications" of your *Benefits Book*.

Who's Eligible

Each team member who satisfies the Plan's eligibility requirements may enroll. Your employment classification determines eligibility to participate in this Plan. For more information regarding employment classification and eligibility, refer to "Chapter 1: An Introduction to Your Benefits" in your *Benefits Book*.

Plan Information

Employer identification number

The Internal Revenue Service (IRS) has assigned Wells Fargo the employer identification number (EIN) **41-0449260**. Use this number if you correspond with the government about the Plan. The Plan is part of an umbrella group health plan called The Wells Fargo & Company Health Plan; the Plan number is **504**.

Plan sponsor

Wells Fargo is the plan sponsor. Please use the address below for any correspondence, and include the EIN:

Wells Fargo & Company
MAC A0101-121
420 Montgomery Street
San Francisco, CA 94104

Plan administrator

The plan administrator has full discretionary authority to administer and interpret the Plan. Wells Fargo & Company is the plan administrator and may delegate

its duties and discretionary authority to accomplish those duties to certain designated personnel, including but not limited to the Director of Human Resources and the Director of Compensation and Benefits.

The plan administrator's address is:

Wells Fargo & Company
MAC N9311-170
625 Marquette Avenue
Minneapolis, MN 55479

To contact the plan administrator or if you have questions about the Plan, you may also call the HR Service Center at 1-877-HRWELLS (1-877-479-3557).

Agent for service

Wells Fargo & Company's corporate secretary (address listed below) is the designated agent for service of legal process for this Plan. You can also serve legal process on the plan administrator or the plan trustee at the addresses listed above and below.

Corporate Secretary
Wells Fargo
MAC N9305-173
Sixth and Marquette
Minneapolis, MN 55479

No legal action can be made to recover expenses until the Plan's claims and appeals procedures have been exhausted (refer to "Appendix A: Claims and Appeals" in the *Benefits Book*). Any suit for benefits must be brought within one year from the date the final appeal determination was issued.

Claims administrator

Anthem Blue Cross Blue Shield is the organization designated by the plan administrator to receive, process, and administer benefit claims according to Plan provisions and to disburse claim payments and information (the "claims administrator"). Contact Anthem Blue Cross Blue Shield at the following address for service of legal process on the Plan's claims administrator:

Anthem Blue Cross Blue Shield
PO Box 37110
Louisville, KY 40233

Plan trustee

The trustee for the Plan is:

Wells Fargo Bank, N.A.
MAC N9303-09A
608 2nd Avenue South
Minneapolis, MN 55479

Plan year

Financial records for the Plan are kept on a "plan year" basis. The plan year begins January 1 and ends the following December 31, unless otherwise designated in the Plan document.

Participating Employers

The Plan generally covers team members and retirees of Wells Fargo and those subsidiaries and affiliates of Wells Fargo that have been authorized to participate in the Plan. These participating Wells Fargo companies are called participating employers. Participants and beneficiaries in the Plan may receive, on written request, information as to whether a particular subsidiary or affiliate is a participating employer of the Plan, and if it is, the participating employer's address. To request a complete list of participating employers in the plans, write to the plan administrator at the address above.

Future of the Plan

Wells Fargo reserves the right to amend or discontinue any benefit or plan, at any time, for any reason.

Plan amendments

Wells Fargo, by action of its Board of Directors, the Human Resources Committee of the Board of Directors, or that of a person so authorized by resolution of the Board of Directors or the Human Resources Committee, may amend the Plan at any time. In addition, Wells Fargo's Director of Human Resources or Wells Fargo's Director of Compensation and Benefits may amend the Plan to (a) comply with changes in applicable laws or regulations; (b) add or amend Appendixes to the Plan; or (c) make changes in the administration or operation of the Plan to the extent that such changes do not materially increase the cost of the Plan to Wells Fargo.

Plan termination

The Board of Directors of Wells Fargo may terminate the Plan at any time. Wells Fargo, by written action of its Chairman, President, the Executive Vice President and Director or HR or the Senior Vice President of Compensation and Benefits may terminate the Plan at any time as it applies to the employees of a participating employer.

Chapter 2

Anthem Blue Cross Blue Shield PPO Plan

How the Plan Works

Introduction

This Summary Plan Description (SPD) contains a summary of the Anthem Blue Cross Blue Shield (Anthem BCBS) PPO Plan coverage option under the Wells Fargo Health Plan for benefits effective January 1, 2010.

This Plan, financed and administered by Wells Fargo & Company, is a self-insured medical plan. Anthem Blue Cross Blue Shield is the claims administrator and provides administrative services only. The claims administrator does not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity.

You may choose any eligible provider of health services for the care you need.

Providers are designated as BlueCard PPO or out-of-network providers. This designation is determined by service agreements with the Anthem Blue Cross Blue Shield organization(s) in the state in which services are rendered.

Choosing a health care provider

BlueCard PPO providers

These providers have entered into a service agreement that designates them as a BlueCard PPO provider with their local Blue Cross Blue Shield organization. To receive the highest level of benefits for the least out-of-pocket expense, you must choose BlueCard PPO providers. These providers will:

- Accept payment based on the allowed amount as determined by Anthem BCBS. The allowed amount is the negotiated amount of payment that BlueCard PPO providers have agreed to accept as full payment for a covered service based on their contract with Anthem BCBS
- File claims for you

For information about the benefits available through these providers, refer to the "Benefits Chart" section.

Out-of-network providers

- Non-BlueCard PPO providers are providers who have entered into a service agreement with the local Blue Cross Blue Shield organization but whose agreement does not designate them as a BlueCard PPO provider. When you choose these providers, benefits will be paid at the out-of-network level. Most of these providers will:
  - Accept payment based on the allowed amount as determined by Anthem BCBS. In most cases, the allowed amount is the negotiated amount of payment that BlueCard PPO providers have agreed to accept as full payment for a covered service based on their contract with Anthem BCBS. However, if a provider does not accept the allowed amount as determined by Anthem BCBS, you will be required to pay the portion of the expense above the allowed amount, in addition to any deductible and coinsurance
  - File claims for you

For information about the benefits available through these providers, refer to the "Benefits Chart" section.

- All other out-of-network providers have not entered into a service agreement with the local Blue Cross Blue Shield organization. When you receive services from out-of-network providers, benefits are based on the allowed amount as determined by the local Blue Cross Blue Shield organization or Anthem BCBS. Therefore, you will have substantial out-of-pocket expenses when you use an out-of-network provider because you are required to pay the portion of the expense that is above the allowed amount, in addition to any deductible and coinsurance. Benefits are paid to you directly and you are responsible for paying the provider. These providers are not obligated to:
  - Accept payment based on the allowed amount
  - File claims for you

For benefits information on these providers, refer to the "Benefits Chart" section.

Charges that are your responsibility

When you use BlueCard PPO providers for covered services, payment is based on the allowed amount as determined by Anthem BCBS. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

- Deductibles
- Coinsurance
- Charges that exceed the benefit maximum
- Charges for services that are not covered

When you use out-of-network participating providers for covered services, payment is still based on the allowed amount as determined by Anthem BCBS. Most out-of-network participating providers agree to accept the allowed amount as payment in full. If not, you are required to pay all charges that exceed the allowed amount. In addition, you are required to pay the following amounts:

- Deductibles
- Coinsurance
- Charges that exceed the maximum benefit level
- Charges for services that are not covered

When you use out-of-network nonparticipating providers for covered services, payment is still based on the allowed amount as determined by Anthem BCBS. However, because an out-of-network nonparticipating provider has not entered into a service agreement with the local Blue Cross Blue Shield organization, that provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expenses when you use an out-of-network nonparticipating provider. You are required to pay the following amounts:

- Charges that exceed the allowed amount
- Deductibles
- Coinsurance
- Charges that exceed the benefit maximum level
- Charges for services that are not covered, including services that the claims administrator, in its full discretion, determines are not covered based on claims coding and coverage guidelines

When you obtain health care services through the BlueCard Program outside the geographic area Anthem BCBS serves, the amount you pay for covered services is usually calculated on the lower of either:

- The billed charges for your covered services
- The negotiated price that the local Blue Cross Blue Shield organization ("Host Blue") passes on to the claims administrator

Often, this "negotiated price" consists of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, the negotiated price is either (1) an estimated price that factors expected settlements, withholds, any other contingent payment arrangements, and nonclaims transactions with your health care provider or with a specified group of providers into the actual price; or (2) billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will be prospectively adjusted to correct for over- or underestimation of past prices. The amount you pay, however, is considered a final price and will not be affected by the prospective adjustment.

Statutes in a small number of states may require the Host Blue to either (1) use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim; or (2) add a surcharge. If any state statutes mandate liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, the claims administrator will calculate your liability for any covered health care services according to the applicable state statute in effect at the time you received your care.

Recommendations by health care providers

In some cases, your provider may recommend or provide written authorization for services that are specifically excluded by this Plan. When these services are referred or recommended, a written authorization from your provider does not override any specific Plan exclusions.

Time periods

When determining benefits, and when coverage starts and ends, a day begins at 12:00 a.m. and ends at 11:59 p.m.

Medical policy committee

The claims administrator's medical policy committee determines whether specific medical treatments are eligible for coverage. The committee is made up of independent, community physicians who represent a variety of medical specialties. The committee's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The committee carefully examines the scientific evidence and outcomes for each treatment being considered. The committee, at its discretion, determines if new treatments will be covered.

Notification Requirements

Prior authorization

The claims administrator reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care. All services must be medically necessary to be covered by the Plan. Prior authorization from the claims administrator is recommended before you receive selected services so that you avoid incurring charges for services that may not be considered medically necessary.

It is your responsibility to determine whether your provider will obtain prior authorization for you. If your provider does not provide this service, or if you are using an out-of-network provider, you will need to obtain prior authorization yourself. If you receive services from a BlueCard PPO provider, in most cases, prior authorization will be obtained for you. If you purchase durable medical equipment or prosthetics that are $1,000 or more, prior authorization is required for in-network and out-of-network providers. For all other services received from out-of-network providers, it is recommended that you receive prior authorization to help you make informed decisions about covered services. The claims administrator recommends that you or the provider contact them at least 10 business days prior to receiving the care to determine if the services are eligible. The claims administrator will notify you of its decision within 10 business days, provided that the prior authorization request contains all the information needed to review the service.

This Plan guarantees payment for preauthorized services if the services are otherwise covered under the Plan and you are covered on the date you receive care. All applicable exclusions, deductibles, and coinsurance provisions continue to apply. The prior authorization will indicate a specified time frame in which you may receive the services. If the service is not performed within this specified time frame, you will need to obtain authorization again prior to receiving the service. You will be responsible for payment of services that the claims administrator determines not to be medically necessary.

Prior authorization is required for certain services. The following list of services requiring preauthorization is subject to change in accordance with medical policy. Call customer service for the most current list.

- Bariatric procedures
- Cosmetic versus medically necessary procedures — including but not limited to blepharoplasty, rhinoplasty, panniculectomy, and lipectomy/ diastasis recti repair, insertion, or injection of prosthetic material collagen implants, chin implant, mentoplasty, or osteoplasty mandible
- Coverage of routine care related to cancer clinical trials
- Dental and oral surgery including, but not limited to: services that are accident-related for the treatment of injury to sound and healthy natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery
- Drugs administered in an office or outpatient setting — including but not limited to:
  - Intravenous immunoglobulin (IVIG)
  - Subcutaneous immunoglobulin
  - Rituximab
  - Alefacept (Amevive®)
  - Efalizumab (Raptiva®)
  - Growth hormone and treatment of IGF-1 deficiency
  - Leuprolide acetate (Lupron), for all uses except for cancer-related diagnoses
  - Omalizumab (Xolair®) for allergic asthma
  - Hemophilia factor products
- Durable medical equipment and certain supplies, prosthetics, or devices including but not limited to:
  - Motorized wheelchairs: special sized, motorized for powered and accessories
  - Hospital beds, rocking beds, and air beds
  - Electronic or externally powered prosthetics
  - Custom made orthotics and braces
- Home health care
- Hospice care
- Home infusion

- Humanitarian and compassionate use devices (procedures using devices under the FDA category of humanitarian and compassionate use device exemption)
- Hyperhidrosis surgery
- Left ventricular assist devices
- Lumbar spinal surgeries (fusion only)
- Orthognathic surgery
- Out-of-network services or durable medical equipment exceeding $1,000
- Refractive eye surgery
- Gender reassignment surgery
- Spinal cord stimulators
- Subtalar arthroereisis for treatment of foot disorders
- Surgical treatment of obstructive sleep apnea and upper airway resistance syndrome
- Temporomandibular joint disorder (TMJ) surgical procedures
- Requests for out-of-network referrals that are determined to be medically necessary based on network adequacy
- Transplants, except cornea
  - Autologous and allogeneic islet cell transplants
  - Organ transplant procedures
  - Cord blood, peripheral stem cell, and bone marrow procedures
  - Donor leukocyte infusion
- UPPP Surgery (Uvulopalatopharyngoplasty – correction for sleep apnea)
- Vagus nerve stimulation (for all conditions)

All requests for prior authorization must be submitted to the claims administrator in writing. Please submit your request using the mailing address provided in the "Contacts" section.

Preadmissions certification

Preadmissions certification is required at least five days in advance of being admitted for inpatient care for any type of nonemergency service. With preadmissions certification, this Plan guarantees payment for days or services that the claims administrator authorizes if the services are otherwise covered under the Plan, and you are covered on the date you receive the services.

If you receive services from a BlueCard PPO provider, preadmissions certification will be obtained for you. You are responsible for providing preadmissions certification to the claims administrator when you receive nonemergency care from out-of-network providers, if your provider does not provide this service for you.

Preadmissions certification is required for the following facilities:

- Hospitals
  - Acute care admissions
  - Elective admissions
  - Emergency admissions (within 48 hours of admission)
  - Newborn stays following discharge of the mother
  - Obstetric-related admissions other than childbirth
  - Rehabilitation admissions
- Skilled nursing facilities
- Long-term acute care facilities

To provide preadmissions certification, call the customer service number provided in the "Contacts" section. They will direct your call.

Emergency admission notification

Notice is required as soon as reasonably possible for admission for pregnancy, a medical emergency, or injury that occurred within 48 hours before admission.

If you receive services from a BlueCard PPO provider, emergency admission notification will be obtained for you. You are responsible for providing emergency admission notification to the claims administrator as soon as reasonably possible when you use an out-of-network provider, if your provider does not provide this service for you.

The Plan pays only for services that the claims administrator determines are medically necessary. To provide emergency admission notification, call the customer service number provided in the "Contacts" section. They will direct your call.

Special Plan Features

Future Moms Maternity Program

Future Moms is the Anthem BCBS maternity program for routine to high-risk maternity cases. Available through a 24-hour toll-free phone number, registered nurses assist mothers-to-be by helping them understand their condition and the vital role they play in their own health.

Members in the Future Moms program live from coast to coast. And whether it's their first child or their fifth, expectant mothers usually share something in common: questions about their pregnancies and what to expect as their child develops. Anthem designed its 360˚ Health spectrum of programs, including the Future Moms program, to be convenient and helpful to mothers-to-be. Through a toll-free phone number, program participants have 24-hour access to registered nurses who can answer their questions and help them follow their pregnancy provider's plan of care.

ConditionCare (Disease Management) Program

As part of our 360° Health strategy, Anthem designed its ConditionCare program to help maximize member health status and improve health outcomes associated with the following prevalent conditions:

- Asthma (pediatric and adult)
- Diabetes (pediatric and adult)
- Heart failure (HF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)

Anthem's staff of health professionals includes registered nurses (RNs), pharmacists, registered dietitians, respiratory therapists, exercise physiologists, licensed social workers, and medical directors. Sharing their expertise on a member-specific basis, they collaborate to help members overcome barriers to attaining improved health and adhering to the treating physician's prescribed plan of care.

MyHealth Coach Program

MyHealth Coach targets the top tier of health care users. MyHealth Coach nurses serve as a central point of contact for individuals who have questions about health care, a condition, benefits, claim payment, or language in an "Explanation of Benefits" statement. Members can also turn to their MyHealth Coach when they simply do not know where to go.

Anthem nurses guide the member through their inpatient admission with preadmission counseling and clinical education that follows a member through medically appropriate intervention points specific to the severity of the member's condition and treatment plan. Additionally, MyHealth Coaches perform postdischarge planning, which may require arranging for services like outpatient rehabilitation or home health care. MyHealth Coaches also reach out to members before and after hospitalizations to ensure that members are prepared before they go in for a procedure and after they are discharged.

24/7 NurseLine

With the Anthem BCBS URAC-accredited 24/7 NurseLine, available 24 hours a day via a convenient toll free number, members can receive one-on-one counseling with experienced Anthem nurses.

The 24/7 NurseLine also offers access to hundreds of audiotapes on a wide variety of health topics. At any time during the message, callers may speak with an Anthem registered nurse for one-on-one consultation. This service is available nationwide via a convenient 24-hour toll-free number. The 24/7 Nurseline number is 1-866-220-4849.

ComplexCare

The ComplexCare program is designed to help participants and their families effectively manage their health to achieve improved health status and quality of life, as well as decrease the use of acute medical services. To achieve this goal, ComplexCare combines the benefits of assigned nurse care managers, goal-setting, and behaviorally appropriate education to help improve member care and health status via intense interventions over a defined time frame.

ComplexCare nurses work with enrolled members and their physicians to promote healthier lifestyles, adherence to evidence-based medicine and self-care through education and self-help tools.

Benefits Chart

This section lists covered services and your costs under this Plan. All benefit payments are based on the allowed amount, as determined by Anthem BCBS. You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider. Coverage is subject to all other terms and conditions of this SPD and must be medically necessary as defined by the Plan (See the "What the plan covers" section.)

Your costs at a glance

Benefit Features	BlueCard PPO Providers	Out-of-Network Benefits
• Office visits copay; maximum visits apply to some service categories	You pay 20% after the deductible	You pay 40% after the deductible
• Preventive care	Plan pays 100% for qualifying preventive care services, based on annual exam schedule	You pay 40%; no deductible
• Urgent care • Emergency room (ER) — must meet emergency care criteria	You pay 20% after the deductible	You pay 40% after the deductible You pay 20% after the deductible
• Hospital and outpatient care: – Hospital care (inpatient care or other care rendered in a hospital setting) requires prior authorization – Outpatient surgery, some services require prior authorization	You pay 20% after the deductible	You pay 40% after the deductible
Deductible	$300 per person per calendar year $600 per family per calendar year	$400 per person per calendar year $800 per family per calendar year

Benefit Features	Limitations and Maximums
Out-of-Pocket Maximums	
BlueCard PPO providers Excludes out-of-network deductible, out-of-network coinsurance amounts, and mail order or retail prescription drug expenses	$2,300, per person per calendar year, includes deductible $4,600, per family per calendar year, includes deductible
Out-of-network providers Excludes charges above the allowed amount, in-network deductible, in-network coinsurance amounts, and mail order or retail prescription drug expenses	$4,400, includes deductible, per person per calendar year $8,800, includes deductible, per family per calendar year
Lifetime Maximum	
Infertility services	$10,000 lifetime maximum benefit per person (see the "Infertility treatment" section)
Total benefits paid to all providers combined	No maximum (except for infertility services)

What the plan covers

The Anthem BCBS PPO Plan covers medically necessary services as determined by Anthem BCBS medical policy and specific plan provisions. In the absence of specific medical policy, medically necessary covered services are health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are determined by Anthem BCBS, at its discretion, to be all of the following:

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors.

When more than one definition or provision applies to a service, the most restrictive applies and exclusions take precedence over general benefit descriptions.

The Plan only covers care provided by health care professionals or facilities licensed, certified, or otherwise qualified under state law to provide health care services and acting within the scope of their licensureship or certification.

Please refer to the following pages for a more detailed description of Plan benefits.

Ambulance

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Air or ground transportation for basic or advanced life support from the place of departure to the nearest facility equipped to treat the illness	You pay 20% after the deductible	You pay 20% after the deductible
• Medically necessary, prearranged, or scheduled air or ground ambulance transportation requested by an attending physician or nurse	You pay 20% after the deductible	You pay 20% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- If the claims administrator determines that air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the allowed amount for medically necessary ground ambulance.

Not covered:

- Transportation services that are not medically necessary for basic or advanced life support.
- Transportation services that are mainly for your convenience.
- Please refer to the "General Exclusions" section.

Bariatric surgery

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Medically necessary inpatient hospital or facility services for bariatric surgery – Semiprivate room and board and general nursing care (private room is covered only when medically necessary) – Intensive care and other special care units – Operating, recovery, and treatment rooms – Anesthesia – Prescription drugs and supplies used during a covered hospital stay – Lab and diagnostic imaging	You pay 20% after the deductible when you use Blue Distinction Centers for Bariatric Surgery No coverage for any other BlueCard PPO provider	No coverage
• Medically necessary outpatient hospital or facility services for bariatric surgery: – Scheduled surgery or anesthesia – Lab and diagnostic imaging – All other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery	You pay 20% after the deductible when you use Blue Distinction Centers for Bariatric Surgery No coverage for any other BlueCard PPO provider	No coverage

Other notes:

- Please see the "Notification Requirements" section.
- As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.
- Prior authorization is required for bariatric surgery procedures. The claims administrator requests prior authorizations be submitted in writing to:

  Anthem UM Services, Inc.
  PO Box 7101
  Indianapolis, IN 46207

- If you live more than 50 miles from a Blue Distinction Center for Bariatric Surgery, there may be benefits available for travel, meals, and lodging expenses directly related to a preauthorized surgery. For more information, please call customer service.
- For a list of Blue Distinction Centers for Bariatric Surgery, call customer service or visit the claims administrator's website.
- For pre- and postoperative bariatric services, please refer to the "Hospital inpatient" section, the "Hospital outpatient" section, and the "Physician services" section.
- For professional services related to eligible bariatric surgery services, please refer to the "Physician services" section.
- Blue Distinction Centers for Bariatric Surgery are designated facilities within the participating Blue Cross Blue Shield organization's service areas that have been selected after a rigorous evaluation of clinical data that provided insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross Blue Shield organizations and the Blue Cross Blue Shield Association.

Not covered:

- Panniculectomy

Chiropractic care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
Chiropractic care (26 visits per calendar year maximum)	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Chiropractic care is limited to a maximum benefit of 26 visits per person per calendar year for all providers combined.
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and chiropractor's time.
- You pay all charges that exceed the allowed amount as determined by BCBS when you use an out-of-network provider.

Not covered:

- Vocational rehabilitation, except when medically necessary and provided by an eligible health care provider.
- Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages), or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, and massage therapy, and all related material and products for these programs.
- Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy to treat the condition.
- Please refer to the "General Exclusions" section.

Dental care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Accident-related dental services from a physician or dentist for the treatment of an injury to sound, natural teeth • Treatment of cleft lip and palate when the service is scheduled or initiated prior to the child turning 19 • Surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Accident-related dental services, treatment, and/or restoration of a sound natural tooth if services are performed within 12 months of the date of injury. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Coverage for treatment and/or restoration is limited to reimplantation of original sound natural teeth, crowns, fillings, and bridges.
- The Plan covers anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is a child under age five, is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For facility charges, please refer to the "Hospital inpatient" section or the "Hospital outpatient" section.
- Oral surgeon or dentist professional fees are not covered. Covered services are determined based on established medical policies, as determined by Anthem BCBS, which are subject to periodic review and modification by the medical directors.
- Treatment for cleft lip and palate includes inpatient and outpatient expenses arising from medical and dental treatment, including orthodontia and oral surgery. For medical services, please refer to the "Hospital inpatient" section, the "Hospital outpatient" section, and the "Physician services" section.
- Treatment for cleft lip and palate is limited to services that are scheduled or initiated before the dependent child turns age 19.
- Services for nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder include removable appliances for TMJ. Covered services do not include fixed or removable appliances which involve movement or repositioning of the teeth or operative restoration of the teeth or prosthetics.
- Orthognathic surgery is covered for the treatment of TMJ and craniomandibular disorder, as determined by Anthem Blue Cross Blue Shield's medical policy criteria.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures, or dental prosthesis.
- A sound natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound natural tooth.
- Dependent child is defined by the age limit for a dependent child or student dependent child, whichever is later, if applicable, as specified in this plan.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Accident-related dental services performed within 12 months from the date of injury.
- Any other dental procedure or treatment.
- Dental services to treat an injury from biting or chewing.
- Dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts.
- Dental implants and any associated services and/or charges.
- Oral surgery and associated expenses, except as noted above.
- Osteotomies and other procedures associated with the fitting of dentures or dental implants.
- Dental braces or orthodontia services and all associated expenses.
- Dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia, except as noted above
- Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums and all associated expenses, including hospitalizations and anesthesia, except as noted above
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomamly and all associated expenses, including hospitalizations and anesthesia, except as noted above
- Please refer to the "General Exclusions" section.

Emergency care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
Emergency room — for emergency care as defined by the Plan	You pay 20% after the deductible	You pay 20% after the deductible
Outpatient health care professional charges	You pay 20% after the deductible	You pay 20% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- When determining if a situation is a medical emergency, the claims administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care. Emergency care is treatment required, generally within 24 hours of onset, to avoid jeopardy to life or health.

Not covered:

- Nonemergency use of the emergency room, as determined by Anthem BCBS.
- Please refer to the "General Exclusions" section.

Home health care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Skilled care ordered in writing by a physician and provided by Medicare-approved or other preapproved home health agency employees, including but not limited to: – Licensed registered nurse – Licensed registered physical therapist – Master's level clinical social worker – Registered occupational therapist – Certified speech and language pathologist – Medical technologist – Licensed registered dietician • Services of a home health aide or social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees • Use of appliances that are owned or rented by the home health agency • Medical supplies provided by the home health agency • Home infusion therapy • Home health care following early maternity discharge; see the "Maternity" section • Palliative care	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- For supplies and durable medical equipment billed by a Home Health Agency, please refer to the "Medical equipment, prosthetics, and supplies" section.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness that may limit the member's life expectancy to two years or less. The service must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Coverage is limited to 100 visits per person per plan year.
- One home health care visit consists of up to four consecutive hours in a 24-hour period.
- The one home health care visit following early maternity discharge does not apply to the 100-visit maximum.
- You pay all charges that exceed the allowed amount when you use an out-of-network provider.

Not covered:

- Custodial or nonskilled care.
- Services of a nonmedical nature.
- Prescription drugs that do not require administration by a health care professional; the prescription drug benefit is administered by CVS Caremark. Please refer to "Chapter 3: Prescription Drug Benefit" for prescription drug coverage information.
- Private duty nursing
- Please refer to the "General Exclusions" section.

Hospice care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Hospice care for terminally ill patients provided by a Medicare approved hospice provider or other preapproved hospice • Inpatient and outpatient hospital care, routine and continuous home nursing care, home health aide visits, physical therapy, speech and language therapy, occupational therapy, social worker visits, durable medical equipment, routine medical supplies, and other supportive services provided to meet the physical, psychological, spiritual, and social needs of the dying individual • In-home lab services, IV therapy, and other supplies related to the terminal illness or injury prescribed by the attending physician or any physician that is part of the hospice care team • Instructions for the care of the dying patient and for the family of the dying individual	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Medical care services unrelated to the terminal illness may be covered according to other Plan benefits and requirements.
- Services provided by the primary care physician are covered but are separate from the hospice benefit.
- Services provided by a skilled nursing facility are covered but are separate from the hospice benefit.
- Prior approval is required for entrance into the hospice benefit, for any inpatient admission while the patient is receiving hospice benefits, for any patient living beyond six months, and for determination of coverage for services unrelated to the terminal illness.
- Benefits are restricted to terminally ill patients with a life expectancy of six months or less. The patient's primary physician must certify in writing a life expectancy of six months or less. Hospice benefits begin on the date of admission.
- You pay all charges that exceed the allowed amount when you use an out-of-network provider.

Not covered:

- Room and board expenses in a nonapproved residential hospice facility.
- Please refer to the "General Exclusions" section.

Hospital inpatient

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Semiprivate room and board and general nursing care (private room is covered only when medically necessary) • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Prescription drugs and supplies used during a covered hospital stay • Lab and x-ray diagnostic imaging	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- The Plan covers cornea transplants. For other kinds of transplants, refer to the "Organ and bone marrow transplant coverage" section.
- The Plan covers anesthesia and inpatient hospital charges for dental care provided to a covered person who is a child under age five, is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- Please refer to the "Dental care" section.
- For cardiac care, you have the option of using Blue Distinction Centers for Cardiac Care. Call customer service prior to receiving cardiac care services for a list of Blue Distinction Centers. These facilities have been selected through a rigorous evaluation of clinical data, including outcomes of care. Institutions that are a part of the cardiac programs are also subject to periodic reevaluation as criteria continue to evolve. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery).

  If you live more than 50 miles from a Blue Distinction Center for Cardiac Care, there may be benefits available for travel, meals, and lodging expenses directly related to a preauthorized surgery. For more information, please call customer service.
- For bariatric services, you must use Blue Distinction Centers for Bariatric Surgery. Call customer service prior to receiving bariatric care services for a list of Blue Distinction Centers. These facilities have been selected through a rigorous evaluation of clinical data, including outcomes of care. Institutions that are a part of the bariatric programs are also subject to periodic reevaluation as criteria continue to evolve. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgical care services, including inpatient care, postoperative care, follow-up, and patient education.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Communication services.
- Please refer to the"General Exclusions" section.

Hospital outpatient

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Scheduled surgery or anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Physical, occupational, and speech therapy • Lab and x-ray diagnostic imaging • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • All other outpatient hospital care	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- The Plan covers anesthesia and outpatient hospital charges for dental care provided to a covered person who is a child under age five, is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- Please refer to the "Dental care" section.
- For cardiac care, you have the option of using Blue Distinction Centers for Cardiac Care. Call customer service prior to receiving cardiac care services for a list of Blue Distinction Centers. These facilities have been selected through a rigorous evaluation of clinical data, including outcomes of care. Institutions that are a part of the cardiac programs are also subject to periodic reevaluation as criteria continue to evolve. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery).
- For bariatric services, you must use Blue Distinction Centers for Bariatric Surgery. Call customer service prior to receiving bariatric care services for a list of Blue Distinction Centers. These facilities have been selected through a rigorous evaluation of clinical data, including outcomes of care. Institutions that are a part of the bariatric programs are also subject to periodic reevaluation as criteria continue to evolve. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgical care services, including inpatient care, postoperative care, follow-up, and patient education.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness, which may limit the member's life expectancy to two years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers many of the charges incurred for transgender surgery (gender reassignment surgery) for covered persons who meet all of the conditions for coverage. Contact Anthem BCBS for information about conditions for coverage. Transgender surgery benefits are limited to one surgery per covered person per lifetime.

  For transgender surgery benefits, the criteria for diagnosis and treatment are based on the guidelines set forth by the World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc.(HBIGDA).
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Please refer to the "General Exclusions" section.

Infertility treatment

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Artificial and intrauterine insemination procedures • $10,000 lifetime limit	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Charges for or related to infertility services are limited to a lifetime maximum benefit of $10,000 per person.
- Refer to the "Hospital inpatient" section and the "Hospital outpatient" section for facility charges.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Donor ova or sperm
- Infertility prescription drugs
- Reversal of sterilization
- Services and prescription drugs for or related to assisted reproductive technology (ART) procedures, actual or attended impregnation or fertilization (i.e., embryo implantation or transfer, in vitro fertilization, artificial insemination), including but not limited to GIFT and ZIFT except that the Plan does cover artificial and intrauterine insemination procedures as described
- Services and prescription drugs for or related to gender selection services
- Sperm banking
- Services exceeding the lifetime maximum for this benefit
- Please refer to the "General Exclusions" section

Maternity

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Health care professional office visit services for prenatal and postnatal care	You pay 20% after the deductible	You pay 40% after the deductible
• Outpatient hospital or facility charges for prenatal and postpartum care	You pay 20% after the deductible	You pay 40% after the deductible
• Inpatient hospital care, including delivery	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- The baby must be enrolled within 60 days after birth (child must be added to coverage through Wells Fargo — refer to "Chapter 1: An Introduction to Your Benefits" in your *Benefits Book*). If the baby is not enrolled during this time period, you must wait until the next open enrollment to enroll the child.
- The Plan covers one home health care visit within four days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours (or 96 hours) mentioned above. See the "Home health care" section.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Adoption
- Child-birth classes
- A surrogate's pregnancy on your behalf and related obstetric/maternity benefits
- Please refer to the "General Exclusions" section

Medical equipment, prosthetics, and supplies

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Durable medical equipment, including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds • Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings • Insulin pumps, glucometers, and related equipment and devices • Blood and blood plasma • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Corrective lenses for aphakia • Hearing devices for children up to age 18 up to a maximum benefit of $5,000 every three calendar years	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- If you purchase durable medical equipment or prosthetics that are $1,000 or more, prior authorization is required for in-network and out-of-network providers.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- For coverage of insulin and diabetic supplies, refer to "Chapter 3: Prescription Drug Benefit."
- Rental of an electric breast pump is eligible for coverage only when there is maternal-infant separation due to illness, prematurity, or hospitalization and only for the duration of the separation.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Blood pressure monitoring devices
- Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- Duplicate equipment, prosthetics, or supplies
- Eyeglasses, contact lenses, or other optical devices or professional services to fit or supply them, except as provided in this benefits chart
- Hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustment, except as specified in this benefits chart
- Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs
- Personal and convenience items, or items provided at levels that exceed the claims administrator's determination of medically necessary
- Rental or purchase of manual breast pump and/or the purchase of an electric breast pump
- Scalp hair prosthesis (wigs)
- Services for or related to arch supports, orthopedic shoes, and foot orthotics, except as needed for foot amputees only

- Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including but not limited to exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants
- Solid or liquid food, food substitutes, food supplements, standard and specialized infant formula, banked breast milk, nutritional supplements, and electrolyte solution, except when administered by tube feeding as the definitive treatment of an inborn metabolic disorder such as phenylketonuria (PKU)
- Oral or dental prosthesis
- Please refer to the "General Exclusions" section

Organ and bone marrow transplant coverage

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
The following medically necessary human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures: • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell support procedures • Autologous bone marrow transplant and peripheral stem cell support procedures • Heart • Heart and lung • Kidney • Kidney — pancreas transplant performed simultaneously (SPK) • Liver — deceased donor and living donor • Lung — single or double • Pancreas transplant – deceased donor and living donor segmental – Pancreas transplant alone (PTA) – Simultaneous pancreas and kidney transplant (SPK) – Pancreas transplant after kidney transplant (PAK) • Small-bowel or small-bowel and liver • The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan: – Potential donor testing – Donor evaluation and workup – Hospital and professional services related to organ procurement	You pay 20% after the deductible for covered services received at Blue Distinction Centers for Transplant (BDCT) providers or other participating BlueCard PPO transplant providers If you live more than 50 miles from a BDCT provider, there may be benefits available for travel, meals, and lodging expenses directly related to a preauthorized transplant	No coverage

Other notes:

- As technology changes, the covered transplants listed above will be subject to modifications in the form of additions or deletions, when appropriate.
- Cornea transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for organ and bone marrow transplants listed above. See the "Hospital inpatient" section and the "Physician services" section.
- If a separate charge is made for a bone marrow or stem cell search from a donor who is not biologically related to the patient, a maximum benefit of $25,000 is payable for charges made in connection with the search.
- Prior authorization is required for all transplant and stem cell support procedures. All requests for prior authorization must be submitted in writing to:

  Anthem Blue Cross Blue Shield
  Transplant Coordinator
  PO Box 7101
  Indianapolis, IN 46207

- If you have specific questions on organ and bone marrow transplant coverage, call the Transplant Coordinator of Anthem Blue Cross Blue Shield, Monday through Friday, from 8:00 a.m. to 6:00 p.m. Central Time at 1-800-824-0581 or contact Customer Service at 1-866-418-7749.

Not covered:

- Benefits for travel, meals, and lodging expenses when you are using a non-BDCT provider.
- Services performed by an out-of-network provider.
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants.
- Services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered.
- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary.
- Living donor organ and/or tissue transplants unless otherwise specified in this SPD.
- Transplantation of animal organs and/or tissue.
- Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan.
- Kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan.
- Travel expenses for a kidney donor.
- Additional exclusions are listed in the "General Exclusions" section.

Definitions:

- **Blue Distinction Centers for Transplants (BDCT) Provider.** A hospital or other institution that has a contract with the Blue Cross Blue Shield Association* to provide organ or bone marrow transplant or peripheral stem cell support procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are reevaluated annually to ensure that they continue to meet the established criteria for participation in this network. For a list of Blue Distinction Centers for Transplants, contact customer service.
- **Participating Transplant Provider.** A hospital or other institution that has a contract with Anthem Blue Cross Blue Shield or with their local Blue Cross Blue Shield organization to provide organ or bone marrow transplant or peripheral stem cell support procedures.

* An association of independent Blue Cross Blue Shield organizations.

Physical therapy, occupational therapy, speech therapy

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
Limited to 90 visits per calendar year, in and out of network and combined for the following: • Physical therapy • Occupational therapy • Speech therapy for: – A congenital defect for which corrective surgery has been performed – An injury or sickness except for mental or personality disorder – Benefits are paid for services of a licensed speech therapist for treatment given to a child under age five (up to the calendar year in which the child turns five) whose speech is impaired due to one of the following conditions: ° developmental delay ° hearing impairment ° major congenital anomalies that affect speech, such as but not limited to cleft lip and cleft palate	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- For lab and diagnostic imaging services billed by a health care professional, please refer to the "Physician services" section. For lab and diagnostic imaging services billed by a facility, please refer to the "Hospital inpatient" section or the "Hospital outpatient" section.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages) or educational therapy, or forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, and massage therapy, and all related material and products for these programs.
- Services related to developmental delay, except as noted under speech therapy in the table above.
- Speech therapy that has not been preapproved by Anthem BCBS.
- Speech therapy for voice modulation, articulation, or similar training.
- Speech therapy to treat stuttering, stammering, or the elimination of a lisp.
- Speech therapy for treatment for delayed speech or language development, except as specifically covered above; delayed speech or language development means that the individual has been unable to acquire the skills expected of a person of that particular age.
- Please refer to the "General Exclusions" section.

Physician services

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Office visits for illness. Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and physician time • Retail health clinic visit • Charges for telephone, email, and internet consultation, as well as telemedicine • Injectable drugs administered by a health care professional that are not self-injectable • Diabetes outpatient self-management training and education, including medical nutrition therapy	You pay 20% after the deductible	You pay 40% after the deductible
• Inpatient hospital or facility visits during a covered admission • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization • Assistant surgeon • Cornea transplants	You pay 20% after the deductible	You pay 40% after the deductible
• Outpatient hospital or facility visits	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- If more than one surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre- and postoperative care.
- For cardiac care, you have the option of using Blue Distinction Centers for Cardiac Care. Call customer service prior to receiving cardiac care services for a list of Blue Distinction Centers. These facilities have been selected through a rigorous evaluation of clinical data, including outcomes of care. Institutions that are a part of the cardiac programs are also subject to periodic reevaluation as criteria continue to evolve. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery).
- For bariatric services you must use Blue Distinction Centers for Bariatric Surgery. Call customer service prior to receiving bariatric care services for a list of Blue Distinction Centers. These facilities have been selected through a rigorous evaluation of clinical data including outcomes of care. Institutions that are a part of the bariatric programs are also subject to periodic reevaluation as criteria continue to evolve. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgical care services, including inpatient care, postoperative care, follow-up, and patient education.

- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat or cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness that may limit the member's life expectancy to two years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Charges for Christian Science Care in a Christian Science Sanatorium unless the confinement is for a condition that would require a person of another faith to enter a hospital
- Internet or similar network communications for the purpose of scheduling medical appointments, refilling or renewing existing prescription medications, reporting normal medical test results, providing education materials, updating patient information, requesting a referral, and services that would similarly not be charged for an on-site medical office visit
- Cosmetic surgery to repair a physical defect
- Repair of scars and blemishes on skin surfaces
- Separate charges for pre- and postoperative care for surgery
- Please refer to the "General Exclusions" section

Preventive care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Cancer screening as specified below: – Mammograms – Pap smears – Flexible sigmoidoscopies and/or colonoscopies – Fecal occult blood testing – Prostate-specific antigen (PSA) tests, digital rectal exams – Surveillance tests for ovarian cancer (CA125 tumor marker, transvaginal ultrasound, pelvic exam) • Physical exam • Gynecological exam • Immunizations • Osteoporosis screening (radiology services) • Lab services as specified below: – Cholesterol and lipid profile – Thyroid screening – Diabetes screening – Hemoglobin — CBC – Urinalysis • Screening for chlamydia, gonorrhea, syphilis, and HIV	Plan pays 100% for qualifying preventive care services, based on annual exam schedule. U.S. Preventive Services Task Force Guidelines are used to determine the frequency for covered health services.	You pay 40%, no deductible. A $250 annual maximum benefit applies.

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- The Plan covers ovarian cancer screening for women at risk for ovarian cancer.
- Benefits for routine physical exams are limited to one per person per calendar year for all networks combined.
- Benefits for routine gynecological exams are limited to one per person per calendar year for all networks combined.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Educational classes or programs
- Physicals for research or obtaining licensure, employment, or insurance
- Vision exams, eyewear, including lenses, frames, and contact lenses, and fitting, except where eligible in the "Medical equipment, prosthetics, and supplies" section
- Please refer to the "General Exclusions" section

Reconstructive surgery

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Reconstructive surgery that is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly that has resulted in a functional defect as determined by the attending physician • Treatment of cleft lip and palate • Elimination or maximum feasible treatment of port-wine stains	For the level of coverage, see the "Hospital inpatient" section, the "Hospital outpatient" section, and the "Physician services" section.	For the level of coverage, see the "Hospital inpatient" section, the "Hospital outpatient" section, and the "Physician services" section.

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Under the Federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. These mastectomy-related benefits are subject to deductible and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits under the PPO option.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures, or dental prosthesis.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Dentures, regardless of the cause or condition, and any associated services and/or charges, including bone grafts
- Dental implants and any associated services and/or charges
- Repair of scars and blemishes on skin surfaces
- Services related to teeth, the root structure of teeth, or supporting bone and tissue; see the "Dental care" section
- Please refer to the "General Exclusions" section

Skilled nursing facility

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Skilled care ordered by a physician and eligible under Medicare guidelines • Semiprivate room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% after the deductible	You pay 40% after the deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Coverage is limited to a maximum benefit of 100 days per person per calendar year.
- If you are unable to obtain a bed in a BlueCard PPO skilled nursing facility within a 50-mile radius of your home due to full capacity, you may be eligible to receive services at an out-of-network skilled nursing facility at the BlueCard PPO level of coverage.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness or injury
- Treatment, services, or supplies that are not medically necessary
- Private Duty Nursing
- Please refer to the "General Exclusions" section

Well-child care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• The following outpatient services for a dependent child from birth to age 18: – Preventive services – Developmental assessments – Laboratory services – Immunizations	Plan pays 100% for qualifying well-child care services, based on annual exam schedule. U.S. Preventive Services Task Force Guidelines are used to determine the frequency for covered services.	You pay 40%, no deductible

Other notes:

- Please see the "Notification Requirements" section.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.

Not covered:

- Please refer to the "General Exclusions" section.

General Exclusions

In addition to the items stated as "Not covered" in previous sections, the Plan does not pay for:

- Admission for diagnostic tests that can be performed on an outpatient basis
- Autopsies
- Blood pressure monitoring devices
- Charges for Christian Science Care in a Christian Science Sanatorium unless the confinement is for a condition that would require a person of another faith to enter a hospital
- Charges for failure to keep scheduled visits
- Charges for or associated with patient advocacy
- Charges for furnishing medical records or reports
- Charges for giving injections which can be self-administered
- Charges for or related to care that is custodial or not normally provided as preventive care or treatment of an illness. Custodial care includes giving medicine that can usually be taken without help, preparing special foods, and helping you to walk, get in and out of bed, dress, eat, bathe, and use the toilet
- Charges for or related to care that is investigative. A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis. The claims administrator bases a decision on an examination of the following reliable evidence, none of which is determinative in and of itself:
  - The drug or device has not been given approval for marketing by the U.S. Food and Drug Administration at the time the drug or device is furnished
  - The drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials. Phase I clinical trials determine the safe dosages of medication for phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients
  - Medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes compared with the standard means of treatment or diagnosis have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient

Reliable evidence shall also mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers, acceptable to the claims administrator

- Charges the provider is required to write off under another plan, when the other plan is primary payer over the Wells Fargo plan
- Charges the participating provider is required to write off
- Charges for over-the-counter drugs, vitamin or dietary supplements, and investigative or non-FDA-approved drugs
- Charges for physician services for weak, strained, flat, unstable, or imbalanced feet; metatarsalgia or bunions (except open cutting operations); or corns, calluses, or toenails (except removing nail roots and care in the treatment of metabolic or peripheral-vascular disease)
- Charges for physician services or x-ray examinations or mouth conditions due to periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue, except for treatment or removal of malignant tumors; this exclusion includes root canal treatment
- Charges for rehabilitation services that would not result in measurable progress relative to established goals
- Charges that are eligible, paid, or payable, under any medical payment, personal injury protection, automobile, or other coverage (e.g., homeowners insurance, boat owners insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay, or coinsurance requirement of such a policy
- Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- Dentures, regardless of the cause or condition, and any associated services and/or charges, including bone grafts
- Dental implants and any associated services and/or charges
- Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs
- Health services provided in a foreign country, unless required as emergency health services
- Interest or late fees charged due to untimely payment for services
- Internet or similar network communications for the purpose of scheduling medical appointments, refilling or renewing existing prescription medications, reporting normal medical test results, providing education materials, updating patient information, requesting a referral, and services that would similarly not be charged for an on-site medical office visit
- Inpatient hospital room and board expense that exceeds the semiprivate room rate, unless a private room is approved by the applicable claims administrator as medically necessary
- Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- Non-emergency care received outside the United States
- Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy; services that do not involve direct patient contact, such as delivery charges and recordkeeping
- Outpatient prescription drugs whether purchased through mail order or a retail pharmacy; these services are provided through CVS Caremark — see "Chapter 3: Prescription Drug Benefit" for coverage information
- Personal comfort items, such as telephone, television, barber and beauty supplies, and guest services
- Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child)
- Services for dependents not covered under the Plan
- Services for or related to:
  - Behavioral health, mental health care, or behavioral substance abuse treatment; these services are administered through OptumHealth Behavioral Solutions
  - Commercial weight-loss programs, fees or dues, nutritional supplements, food, vitamins, and exercise therapy, and all associated labs, physician visits, and services related to such programs

- Cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the "Reconstructive surgery" section
- Dental or oral care, treatment, orthodontics, or surgery and any related supplies, anesthesia, or facility charges, except as specified in the "Dental care" section
- Fetal tissue transplantation
- Functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits
- Gene therapy as a treatment for inherited or acquired disorders
- Growth hormone, except for conditions that meet medical necessity criteria as determined by the applicable claims administrator prior to receipt of the services
- Hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustments, except as specified in the "Medical equipment, prosthetics, and supplies" section
- Lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the "Medical equipment, prosthetics, and supplies" section
- Private-duty nursing
- Recreational therapy (defined as the prescribed use of recreation and other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, massage therapy, and work-hardening programs, and all related material and products for these programs
- Reversal of sterilization
- Routine physical exams for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such physical examination would normally have been provided in the absence of the third-party request
- Smoking cessation program fees and/or related program supplies
- Therapeutic acupuncture, except for the treatment of chronic pain when treatment is provided through a comprehensive pain management program or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy
- Transportation other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the "Ambulance" section
- Treatment of illness or injury that occurs while on military duty that is recognized by the Veterans Administration as services related to service-connected injuries
- Recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy, or forms of nonmedical self-care or self-help training, including but not limited to health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, and massage therapy, and all related material and products for these programs

- Services needed because you engaged in an illegal occupation or committed or attempted to commit a felony
- Services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include but are not limited to custody evaluation, parenting assessment, education classes for DUI offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs
- Services or supplies that are primarily and customarily used for nonmedical purposes, or used for environmental control or enhancement (whether or not prescribed by a physician), including but not limited to exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants
- Services performed before the effective date of coverage and services received after your coverage terminates, even though your illness started while your coverage was in force

- Any disease or injury resulting from a war, declared or not, any military duty, or any release of nuclear energy.
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- Services for hospital confinement primarily for diagnostic studies.
- Prolotherapy, hippotherapy, or psychosurgery
- Services that are:
  - Normally provided without charge, including services of the clergy
  - Prohibited by law or regulation
  - Provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim
  - Not within the scope, licensure, or certification of a provider
- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood-producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures, except as specified in the "Organ and bone marrow transplant coverage" section
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- The portion of eligible services and supplies paid or payable under Medicare
- Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the "Bariatric surgery" section, the "Hospital inpatient" section, and the "Organ and bone marrow transplant coverage" section
- Treatment, equipment, drug, and/or device that the claims administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to chelation therapy that the claims administrator determines is not medically necessary; services for or related to systemic candidiasis, homeopathy, and/or immunoaugmentative therapy
- Treatments, services, or supplies that are not medically necessary, as determined by Anthem Blue Cross Blue Shield at their discretion. This includes, but is not limited to care, supplies, or equipment that do not meet Anthem Blue Cross Blue Shield's medical policy, clinical coverage guidelines, or benefit policy guidelines
- Vision correction surgery

Claims and Appeals

If you use a network provider, the provider will obtain necessary pre-service authorizations and will file claims for you. However, you are responsible for following up to ensure the claim was filed within the proper time frame as noted below.

If you receive services from an out-of-network provider, it is your responsibility to make sure the claim is filed correctly and on time even if the out-of-network provider offers to assist you with the filing. This means that you need to determine whether your claim is an urgent care (including concurrent care claims), pre-service, or postservice claim. After you determine the type of claim, file the claim as noted below.

More specific information on filing claims can be found in the *Benefits Book*, "Appendix A: Claims and Appeals."

Urgent care claims (and concurrent care claims)

If the Plan requires pre-service approval in order to receive benefits for care or treatment and a faster decision is required to avoid seriously jeopardizing the life or health of the claimant, contact Anthem Blue Cross Blue Shield at 1-866-418-7749 or by fax at 1-317-287-8907 or 1- 800-773-7797.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the Plan requires pre-service approval in order to receive benefits under the Plan, contact Anthem Blue Cross Blue Shield at 1-866-418-7749 or by fax at 1-317-287-5049 or 1- 800-773-7797.

You may also file a written pre-service claim request at the following address:

Anthem UM Services, Inc.
PO Box 7101
Indianapolis, IN 46207

or call Customer Service at 1-866-418-7749.

Post-service claims

For services already received, a post-service claim must be filed with Anthem Blue Cross Blue Shield within 12 months from the date of service, whether you file the claim or the provider files the claim.

If you receive services from an out-of-network provider, you are responsible for ensuring that the claim is filed correctly and on time even if the out-of-network provider offers to file the claim on your behalf. The claim form is included in this book. The claim form is also available at *Teamworks* > Forms Online. Late filing by an out-of-network provider is not a circumstance allowing for submission beyond the stated 12-month time frame.

You must complete the appropriate claim form and provide an itemized original bill* from your provider that includes the following:

- Patient name, date of birth, and patient diagnosis
- Date(s) of service
- Procedure code(s) and descriptions of service(s) rendered
- Charge for each service rendered
- Service provider's name, address, and tax identification number

* Monthly statements or balance due bills are not acceptable. Photocopies are only acceptable if you're covered by two plans and sent your primary payer the original bill.

Claims for separate family members should be submitted separately. If another insurance company pays your benefits first, submit a claim to that company first. After you receive your benefit payment, submit a claim to Anthem Blue Cross Blue Shield and attach the other company's explanation of benefits statements along with your claim. It is important to keep copies of all submissions.

Call Anthem BCBS customer service at 1-866-418-7749 to obtain the correct address to file your out-of-network claim.

Complete information on filing claims can be found in the *Benefits Book*, "Appendix A: Claims and Appeals."

Claims payment

When a claimant uses providers who have signed a BlueCard PPO service agreement with the local Blue Cross Blue Shield organizations, the Plan pays the provider. When a claimant uses an out-of-network provider, the Plan pays the claimant. A claimant may not assign his or her benefits to an out-of-network provider, except when the claimant is a dependent whose parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay an out-of-network provider for covered services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation.

Claims questions, denied coverage, and appeals

If you have a question or concern about a benefit determination, you may informally contact member services before filing a formal appeal. For more information, see the "Contacts" section.

You may also file a formal written appeal with Anthem Blue Cross Blue Shield without first informally contacting the member service department. A written appeal must be filed within 180 days of the date of the adverse determination of your initial claim regardless of any verbal discussions that have occurred regarding your claim.

Complete information on appeals is provided in the *Benefits Book*, "Appendix A: Claims and Appeals."

Coordination of Benefits

When you or your dependents have other group medical insurance (through your spouse's or domestic partner's employer, for example), the Plan may combine with the other plan to pay covered charges. One plan is primary, the other secondary. This is called coordination of benefits (COB). You cannot coordinate benefits between Wells Fargo-sponsored benefits plans. This section applies when you have health care coverage under more than one plan, as defined below. If this section applies, you should look at the "Order of Benefits rules" section below to find out which plan determines benefits first. Your benefits under this Plan will not be reduced if the Order of Benefits rules require this Plan to pay first. Your benefits under this Plan may be reduced if another plan pays first.

Definitions

These definitions apply only to this section.

The term "plan" means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured; this includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage
- Coverage under a government plan or required or provided by law
- Individual coverage; group coverage is always primary and pays first

Therefore, "plan" does not include:

- A state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time)
- Medicare (Title XVIII, United States Code, as amended from time to time) for Medicare benefits paid or payable to any person for whom Medicare is primary
- Any benefits that, by law, are excess to any private or other nongovernmental program

If any of the above coverages include group-type hospital indemnity coverage, the Plan only includes that amount of indemnity benefits that exceeds $100 a day.

"Primary Plan/Secondary Plan" is determined by the Order of Benefits rules.

When this Plan is the primary plan, its benefits are determined before any other plan and without considering the other plan's benefits.

When this Plan is the secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When you are covered under more than two plans, this Plan may be a primary Plan to some plans and may be a secondary Plan to other plans.

"Allowable expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or this Plan.

- The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under this Plan.
- When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

The claim determination period is a calendar year. However, it does not include any part of the year you are not covered under this Plan, or any part of a year before the date this section takes effect.

Order of Benefits rules

- **General.** When a claim is filed under this Plan and another plan, this Plan is the secondary plan and determines benefits after the other plan, unless both of the following are true:
  - The other plan has rules coordinating its benefits with this Plan's benefits.
  - The other plan's rules and this Plan's rules require this Plan to determine benefits before the other plan.
- **Rules.** This Plan determines benefits using the first of the following rules that applies:
  - *Nondependent vs. dependent.* The plan that covers the person as a team member, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
  - *Dependent child of parents not separated or divorced.* When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

- The plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year.
- If both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as a result the plans conflict on the order of benefits, the rule in the other plan determines the order of benefits.

– *Dependent child of parents divorced or separated, or separated through termination of a domestic partner relationship*. If two or more plans cover a dependent child of divorced or separated parents, this Plan determines benefits in this order:
  - First, the plan of the parent with physical custody of the child.
  - Then, the plan that covers the spouse of the parent with physical custody of the child.
  - Finally, the plan that covers the parent not having physical custody of the child.
  - In the case of joint physical custody, the bullets above that describe the birthday provisions apply. However, if the court decree requires one of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.
– *Active vs. inactive team member*. The plan that covers a person as a team member who is neither laid off nor retired (or as that team member's dependent) determines benefits before a plan that covers that person as a laid off or retired team member (or as that team member's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
– *Longer/shorter length of coverage*. If none of the above determines the order of benefits, the plan that has covered a team member, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

How coordination of benefits affects you

- **When this section applies.** When the Order of Benefits rules above require this Plan to be a secondary plan, this part applies. When that occurs, the benefits provided by this Plan may be reduced.
- Reduction in this Plan's benefits when the sum of both:
  – The benefits payable for allowable expenses under this Plan, without applying coordination of benefits
  – The benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period; in that case, the benefits of this Plan are reduced so that benefits payable under all plans do not exceed allowable expenses

When benefits of this Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.

When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. Note that if you are covered under this Plan and Medicare, this Plan will comply with the Medicare Secondary Payer (MSP) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a Primary Plan and which is a secondary plan.

Medicare will be primary and this Plan will be secondary, as permitted by Medicare rules.

Right to receive and release needed information

Certain facts are needed to apply these coordination of benefits rules. The claims administrator has the right to decide which facts are needed. The claims administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, this Plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If this Plan pays more than it should have paid based on the terms of the Plan, this Plan may recover the overpayments from any of the following:

- The persons this Plan paid or for whom this Plan has paid
- Insurance companies
- Other organizations

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

Reimbursement and Subrogation

This Plan maintains both a right of reimbursement and a separate right of subrogation. If you or your dependents, heirs, guardians, executors, or other representatives receive benefits under this Plan arising out of an illness or injury for which a third party is or may be liable, this Plan shall be subrogated to your claims against that third party.

If the Plan pays any benefits and you or your dependent(s) later obtain a recovery, you are obligated under the terms of this Plan to reimburse the Plan for the benefits paid. The Plan will be reimbursed first for 100% of benefits paid by this Plan before you are entitled to keep any amounts, regardless of whether the amounts represent a full or partial recovery by you, or you are made whole, and regardless of whether medical or dental expenses are itemized in a settlement agreement, award, or verdict.

As used in this "Reimbursement and Subrogation" section, amounts means any recoveries, settlements, judgments, or other amounts that you, your dependents, heirs, guardians, executors, attorneys, or other representatives receive, are awarded, or become entitled to from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for (1) the accident, injury, sickness, or condition that resulted in benefits being paid under the Plan; and/or (2) the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the Plan. Until the Plan has been reimbursed for the full amount of all benefits paid under the Plan, all amounts that you, your dependents, your attorneys, or other representatives receive shall be held in constructive trust for the Plan, whether such amounts remain with you or with some other person or entity.

Duty to cooperate

You, your dependents, your attorneys, or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action — including but not limited to settlement of any claim — that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims or amounts for which the Plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the Plan by providing written notification to the claims administrator of:

- Potential or actual claims that you and your dependents have or may have
- The identity of any and all parties who are or may be liable
- The date and nature of the accident, injury, sickness, or condition for which the Plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed

You and your dependents must provide this information as soon as possible, and, in any event, before the earlier of the date on which you, your dependents, your attorneys, or other representatives (1) agree to any settlement or compromise of such claims; or (2) bring a legal action against any other party. In addition, as part of your duty to cooperate, you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement, and provide any other information required by the Plan. A violation of the Reimbursement Agreement is considered a violation of the terms of the Plan.

The Plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The Plan may require you to assign your rights of recovery to the extent of benefits provided under the Plan. The Plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this Plan. Any proceeds collected, held, or received by you, your dependent, your attorney, or any other party to whom such proceeds may be paid by virtue of a settlement of, or judgment relating to, any claim of yours or your dependent(s) that arises from the same event to which payment by the Plan is related, are constructively held in trust for the benefit of the Plan and for the satisfaction of the Plan's subrogation and/or reimbursement claims.

Attorneys' fees

The Plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the Plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependent(s) in connection with any claim or lawsuit against any other party.

The plan administrator may delegate any or all functions or decisions it may have under this "Reimbursement and Subrogation" section to the claims administrator.

What may happen to your future benefits

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the Plan, the Plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys, or other representatives have failed to cooperate with the Plan's subrogation and reimbursement efforts. If the Plan determines that you have failed to cooperate, the Plan may decline to pay for any additional care or treatment for you or your dependent(s) until the Plan is reimbursed in accordance with the Plan terms or until the additional care or treatment exceeds the amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury but will apply to all benefits otherwise payable under the Plan for you and your dependent(s).

Fraudulent practices

Coverage for you or your dependent(s) is subject to termination if you or your dependent(s) submit fraudulent, altered, or duplicate billings for personal gain and/or allow another party not covered under the Plan to use your or your dependent's coverage.

Excessive and harmful use of health care services

The claims administrator monitors claims data for many reasons. If Anthem BCBS determines that you are receiving an excessive number of health care services, Anthem BCBS evaluates the medical necessity of such services. If Anthem BCBS determines that an excessive number of services are not medically necessary, the following will occur:

- The claims administrator will send you a letter giving you 30 days to select one participating physician and one participating hospital to coordinate all of your health care needs. If you do not make a selection, Anthem BCBS will select one for you. After the selection is made, all services must be coordinated by the selected providers. Care received from other providers will not be covered and the charges incurred for that care will be your responsibility.
- The claims administrator will notify you how to obtain care not available through the coordinating health care providers, how to access emergency care, and how long these restrictions will be in place.

The Plan does not pay claims to providers or to team members for services received in countries that are sanctioned by the U.S. Department of Treasury's Office of Foreign Assets Control (OFAC). Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

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Chapter 3

Prescription Drug Benefit

The Basics

CVS Caremark administers the prescription drug portion of this Plan. This means that when you select from CVS Caremark's Primary Preferred drug list, often referred to as a formulary, you'll save money. The drugs on this list were chosen because they've been shown to work well in clinical trials and are cost effective.

Coverage is determined based on the established criteria for the prescription drug plan. Not all medications are covered by the Plan (even if other medications in the same therapeutic class are covered). To obtain information on the established criteria, or to find out if your drug is on the preferred drug list, is covered by the Plan, or is subject to certain Plan provisions, visit www.caremark.com or call Customer Care at 1-800-772-2301 to obtain information about this Plan's prescription drug coverage.

Filling your prescription

You can have your prescriptions filled at any retail pharmacy, but you'll save money if you use a pharmacy that participates in the CVS Caremark Retail Program. Most national and regional retail pharmacies do. When you have a prescription filled at a participating pharmacy, you can take advantage of the discounted network rates and you'll typically pay less than if you have a prescription filled at a nonparticipating pharmacy.

And remember, you'll save even more if you choose a drug from the preferred drug list and/or use CVS Caremark Mail Service Pharmacy.

Retail pharmacies

You can get up to a 30-day supply of most prescriptions at a retail pharmacy. Exceptions include self-injectables, drugs that require special handling, and oral chemotherapy drugs. See the "CVS Caremark Specialty Pharmacy" section for more information.

- Bring your CVS Caremark ID card and pay your portion, as shown in the "What You'll Pay for Prescriptions" section, for up to a 30-day supply of each prescription. Some drugs require prior authorization, so be sure to review the "Some Prescriptions May Require Prior Authorization" section before filling a prescription for the first time.

If you use a nonparticipating retail pharmacy, you'll be asked to pay 100% of the prescription price at the pharmacy and then submit a paper claim form with the original prescription receipt(s) to CVS Caremark. If it's a covered expense, CVS Caremark will reimburse you as shown in the "What You'll Pay for Prescriptions" section, up to a 30-day supply per prescription.

To locate a CVS Caremark participating pharmacy:

- Visit the CVS Caremark website at www.caremark.com.
- Call Customer Care at 1-800-772-2301.
- Ask your retail pharmacy if it participates in the CVS Caremark Retail Program.

CVS Caremark Mail Service

CVS Caremark Mail Service is a great choice for prescriptions that you take on a regular basis, such as cholesterol-lowering drugs or birth control pills. You can order up to a 90-day supply of your prescription through this service — just be sure to ask your doctor to write a prescription for a 90-day supply of each medication, plus refills up to one year, if appropriate. For example, ask your doctor to write a prescription for a 90-day supply with three refills, not a 30-day supply with 11 refills.

With CVS Caremark Mail Service you get:

- Up to a 90-day supply of covered drugs for one copay
- Access to registered pharmacists 24 hours a day, 7 days a week
- Ability to refill orders online, by phone, or by mail — anytime day or night
- Free standard shipping

Ordering prescriptions

Once you have filled a prescription through CVS Caremark, you can order refills by mail in three ways. You should order your refill 14 days before your current prescription runs out. Suggested refill dates will be included on the prescription label you receive from CVS Caremark.

Three ways to order prescriptions:

- **Online.** Go to www.caremark.com. If you are a first-time visitor, you'll need to register using your CVS Caremark ID number (shown on your CVS Caremark ID card). This is the most convenient way to order refills and inquire about the status of your order any time of the day or night.
- **By phone.**
  - For existing prescriptions:

    Call Customer Care at 1-800-772-2301 for fully automated refill service. Have your CVS Caremark ID number ready.

  - For new prescriptions:

    Complete a mail service order form and send it to CVS Caremark along with your prescription.
- **By mail.** Attach the refill label provided with your last order to a mail service order form. Enclose payment with your order, if your plan requires a payment.

You can expect your medicine to arrive approximately 10 calendar days after CVS Caremark receives your prescription. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when you order. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a participating retail pharmacy while your mail-order prescription is being processed.

Overnight or second-day delivery may be available in your area for an additional charge. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medicine that you would receive from a retail pharmacy.

What's Covered

Covered prescriptions

The following prescription types are covered, but some may require prior approval, be limited in the amount you can get at any one time, or are limited by the age of the patient.

- Drugs that legally require a prescription, including compounded drugs where at least one ingredient requires a prescription, subject to the exceptions listed in this chapter
- Diabetic test strips, alcohol swabs, lancets
- Insulin, insulin pen, insulin prefilled syringes, needles, and syringes for self-administered injections
- Oral, injectable, intravaginal, and transdermal contraceptives that require a prescription
- Tobacco-cessation and nicotine replacement drugs that require a prescription
- Vitamins that require a prescription
- Weight loss drugs prescribed to treat an existing comorbid condition(s)

The list of preferred drugs, covered drugs, noncovered drugs, and coverage management programs and processes is subject to change. As new drugs become available, they will be considered for coverage under the Plan as they are introduced.

Diabetic supplies

You can purchase drugs and supplies to control your diabetes for one copay or coinsurance amount when you submit prescriptions for the diabetic supplies at the same time as your prescription for insulin or oral diabetes medication to CVS Caremark Mail Service Pharmacy. Common diabetic supplies include lancets, test strips, alcohol swabs, and syringes or needles. The copay or coinsurance amount you pay will depend on the type of diabetes medication prescribed.

If you purchase diabetic supplies at a retail pharmacy, seperate copays or coinsurance amounts will apply to each item.

Primary Preferred drug list

Certain prescription drugs are preferred, because they help control rising prescription drug costs and are high-quality, effective drugs. This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. The Primary Preferred drug list is reviewed and updated regularly by an independent pharmacy and therapeutics committee to ensure that it includes a wide range of effective generic and brand-name prescription drugs. The list is continually revised to ensure that the most up-to-date information is taken into account. Go to www.caremark.com to see if your prescription is on the list.

Drug categories

The Plan provides coverage for the following types of drugs:

- **Generic prescription drugs.** Your most affordable prescription option.

  The Food and Drug Administration (FDA) ensures that generic drugs meet the same standards for safety and effectiveness as their brand-name equivalents. The brand name is simply the trade name used by the pharmaceutical company to advertise the prescription drug. In the U.S., trademark laws do not allow a generic drug to look exactly like the brand-name drug. Although colors, flavors, and certain inactive ingredients may be different, generic drugs must contain the same active ingredients as the brand-name drug.

- **Preferred brand-name drugs.** Brand-name prescription drugs that are on the primary preferred drug list.

  These drugs may or may not have generic equivalents available.

- **Nonpreferred brand-name drugs.** Brand-name prescription drugs that are covered but are not on the primary preferred drug list.

  Because effective and less costly generic or preferred brand-name drugs are available, you'll pay more for these drugs. However, they are covered under the Plan.

What You'll Pay for Prescriptions

Here's a snapshot of what you'll pay depending on the type of drug and where you get it.

Type of Drug	Network Retail Pharmacy (up to a 30-day supply)	Out-of-Network Retail Pharmacy (up to a 30-day supply)	CVS Caremark Mail Service (up to a 90-day supply)
Generic drugs	You pay a $5 copay.	You pay a $5 copay + (full cost – CVS Caremark discounted amount).	You pay a $10 copay.
Preferred brand-name drugs	You pay 30% of covered charges with $60 maximum per prescription.	You pay 30% of covered charges with $60 maximum per prescription + (full cost – CVS Caremark discounted amount).	You pay 30% of covered charges with $90 maximum per prescription.
Nonpreferred brand-name drugs	You pay 40% of covered charges with $90 maximum per prescription.	You pay 40% of covered charges with $90 maximum per prescription + (full cost – CVS Caremark discounted amount).	You pay 40% of covered charges with $140 maximum per prescription.
Maximum annual out of pocket for prescriptions	NA	NA	$1,000 per individual and $2,000 per family — mail only

The following Plan provisions also apply to all prescription drug claims processing:

- It's standard practice in most pharmacies (and, in some states, a legal requirement) to substitute generic equivalent for brand-name drugs whenever possible.
- If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copayment, plus the difference in cost between the brand-name drug and the generic drug. Any difference in cost between the brand and generic is not applied to any maximum per prescription amount listed above. At mail order, the difference in cost that you pay is not applied to the annual out-of-pocket maximum. If your doctor requests the brand-name drug (i.e., because it is medically necessary), you will pay the nonpreferred brand-name drug coinsurance amount.
- There are no exceptions to any of the copay or coinsurance amounts listed above, even with a physician's request. For example, if the drugs on the preferred list are not appropriate for you, and you choose a drug that's not on the list, you will still have to pay the higher copay or coinsurance amount.
- Prescriptions for certain specialty drugs (typically self-injectables) cannot be filled at retail pharmacies. For more information, see the "CVS Caremark Specialty Pharmacy" section.
- CVS Caremark Mail Service is the only approved mail-order provider. Any drugs ordered by mail from another provider will not be covered.
- Certain prescriptions have quantity limits. Talk to your pharmacist if you have questions about possible quantity limits for your prescriptions.
- You'll need to get prior approval from CVS Caremark for certain prescriptions. For more information, see the "Some Prescriptions May Require Prior Authorization" section.

Your ID Card

Shortly after you enroll in this Plan, you'll receive an ID card from CVS Caremark. You'll need to present your ID card each time you purchase prescription drugs at a participating pharmacy. If you do not have your ID card with you, you can pay for your prescription up front and file a claim for reimbursement.

You can also go to www.caremark.com to print a temporary ID card.

CVS Caremark Specialty Pharmacy

Complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis are treated with specialty drugs. These are typically drugs that are self-injectable or require special handling or oral chemotherapy drugs. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides these products directly to covered individuals along with supplies, equipment, and care coordination.

Contact CaremarkConnect toll-free at 1-800-237-2767 to get:

- Personal attention from experts
- Expedited, confidential delivery to the location of your choice
- Pharmacist-led or nurse-led CareTeam to provide customized care, counseling on how to best manage your condition, patient education, and evaluations to assess your progress on therapy, and to discuss your concerns and help you achieve the best results
- Pharmacists are available 24 hours a day for emergency consultations
- Coordination of home care and other health care services

Some Prescriptions May Require Prior Authorization

With most of your prescriptions, no prior authorization is necessary. However, sometimes doctors write prescriptions that are "off label" (meaning, not for the purpose the drug is normally used for) or for an out-of-the-ordinary quantity, or there may be some other flag that triggers a need for a review.

When you receive a prescription, simply take it to your retail pharmacy or send it to your CVS Caremark Mail Service Pharmacy as described in this chapter. If prior authorization is necessary, your pharmacist or CVS Caremark will let you know. If it's determined that prior authorization is necessary, the provider who prescribed the medication must call 1-800-626-3046 to verify pertinent information necessary for a prior authorization.

After the review is complete, CVS Caremark will send you and your doctor a letter confirming whether coverage has been approved (usually within 48 hours after CVS Caremark receives the information it needs).

If coverage is approved, you'll pay your normal copay or coinsurance amount for your prescription. If coverage is not approved, you will be responsible for the full cost of the medication. Please note that prescriptions may fall under one or more coverage review programs. If coverage is denied, you have the right to appeal the decision. Information about the appeal process will be included in the notification letter you receive.

Below are some examples of drugs that may require prior authorization:

- Anabolic steroids (e.g., Anadrol-50®, Winstrol®, Oxandrolone®)
- Antimalarial agents (e.g., Qualaquin®)
- Botulinum toxins (e.g., Botox®, Myobloc®)
- Dermatologic agents (e.g., Retin-A, Tazorac®)
- Erythroid stimulants (e.g., Epogen®, Procrit®, Aranesp®)
- Growth stimulating agents (e.g., Genetropin®, Norditropin®)
- Immune globulines (e.g., Vivaglobin®)
- Interferon agents (e.g., Intron® A, PegIntron™, Pegasys®)
- Lung infection injections (e.g., Synagis®)
- Multiple sclerosis therapy (e.g., Avonex®, Betaseron®, Copaxone®)
- Narcolepsy treatments (e.g., Provigil®)
- Pain management (e.g., Lidoderm® patches)
- Cancer treaments (e.g., Gleevec®, Avastin®)
- Weight loss drugs (e.g., Meridia®)

Some drugs require what's called "step therapy." This means that a certain drug may not be covered unless you've first tried another drug or therapy. Examples include:

- **Migraine medications.** You may need to try generic sumatriptan (generic Imitrex®) or Relpax® before the Plan will cover other brand-name migraine medications such as Amerge®, Axert®, Frova®, Maxalt®, Migranal ND®, Treximet® and Zomig®.
- **Nasal steroids.** You may need to try generic flutocasone propionate (generic Flonase®) or generic flunisolide (generic Nasarel®) before the Plan will cover other brand-name nasal inhaled steroid medications such as Beconase AQ®, Nasonex®, Omnaris®, Rhinocort Aqua™, or Veramyst®.
- **Osteoporosis medications.** You may need to try alendronate (generic for Fosamax®) or Boniva® before the plan will cover other brand-name osteoporosis medications such as Actonel®.
- **Proton pump inhibitors (PPIs).** You may need to try generic omeprazole (generic Prilosec®) before the Plan will cover other brand-name PPIs such as Aciphex®, Prevacid®, Prilosec®, Protonix®, or Zegrid®.
- **Sleep aids.** You may need try generic zolpidem (generic Ambien®) before the Plan will cover other brand-name sleep aids such as Ambien CR®, Lunesta®, Rozerem®, and Sonata®.

For certain drugs, including the ones listed below, the Plan limits the quantity it will cover. However, a coverage review by CVS Caremark may be available to request additional quantities.

- Antiviral agents (such as Valtrex®, Zovirax®)
- Antiemetic agents (such as Zofran®, Kytril®)
- Migraine therapies (such as Imitrex®, Imitrex®NS, Zomig®, Zomig-ZMT®)
- Oral bronchodilators (such as Albuterol®, Alupent®, Brethaire®, Maxaire®, Proventil®)
- Oral inhaled steroids (such as Advair®, Aerobid®, Azmacort®, Beclovent®, Flovent®, Pulmicort®, Qvar®, Vanceril®)
- Pain medications (such as Actiq®, Fentora®)
- Sleeping medications (such as zolpidem generic for Ambien®, Ambien CR®, Lunesta®, Rozerem®, Sonata®)

Coverage review is not available for antifungal agents (e.g., Sproanox®, Lamisil®, Diflucan®).

Prescriptions That Are Not Covered

The following types of prescription drugs are not covered, even if you get a prescription from your doctor:

- Compounded drugs that do not meet the definition of compounded drugs; medications of which at least one ingredient is a drug that requires a prescription
- Drugs or supplies that are not for your personal use or that of your covered dependent(s)
- Drugs or supplies prescribed to treat any conditions specifically excluded by the Plan
- Drugs that are considered cosmetic agents or used solely for cosmetic purposes (e.g., anti-wrinkle drugs)
- Drugs that treat hair loss, thinning hair, unwanted hair growth, and/or hair removal
- Drugs that are already covered under any government programs, including Workers' Compensation, or medication furnished by any other drug or medical service that you do not have to pay for
- Drugs that are not approved by the FDA, or that are not approved for the diagnosis for which they have been prescribed
- Investigational or experimental drugs, as determined by CVS Caremark in its discretion
- Drugs whose intended use is illegal, unethical, imprudent, abusive, or otherwise improper
- Early refills, **except** in certain emergency situations (e.g., lost medication, traveling abroad). In these situations you may receive up to a 30-day supply at a retail pharmacy or a 90-day supply from CVS Caremark Mail Service. If you are traveling abroad for more than *90 days*, contact Customer Care at 1-800-772-2301. You'll be responsible for any copays or coinsurance amounts.
- Infertility drugs
- Intrauterine devices (IUD)
- Drugs you purchase outside the U.S. that you are planning to use in the U.S.
- Any drug used to enhance athletic performance
- Over-the-counter drugs or supplies, including vitamins and minerals
- Nutritional supplements, dietary supplements, meal replacements, infant formula or formula food products

- Prescriptions requested or processed after your coverage ends; you must be an active participant in the Plan at the time your prescription is processed — not merely on the date your prescription is postmarked — for your prescription to be covered
- Prescriptions dispensed after one year from the original date of issue, more than six months after the date of issue for controlled substances, or if prohibited by applicable law or regulation
- Prescription drug claims received beyond the 12-month timely filing requirement; CVS Caremark must receive claims within 12 months of the prescription drug dispensed date
- Prescription drugs that are not medically necessary, as determined by CVS Caremark in its discretion
- Prescriptions exceeding a reasonable quantity as determined by CVS Caremark in its discretion
- Sexual dysfunction drugs
- Topical antifungal polishes (e.g., Penlac)
- Mail-order prescriptions that are not filled at a CVS Caremark Mail Service facility

The following drugs are not covered by CVS Caremark, but may be covered by the Plan.* Typically, these are administered in your doctor's office.

- Allergy sera or allergens
- Contraceptive devices and inserts that require fitting and/or application in a doctor's office, such as a diaphragm, Depo-Provera, or Norplant
- Injectable drugs that are not typically self-administered as determined by CVS Caremark in its discretion
- Immunization agents or vaccines (except Zostavax® or Vivotif Berna)
- Any drugs you are given at a doctor's office, hospital, extended care facility, or similar institution
- Therapeutic devices, appliances, and durable medical equipment, except for glucose monitors

* Check "Chapter 2: Anthem Blue Cross Blue Shield PPO Plan" for information about possible coverage.

This list is subject to change. To determine if your prescription is covered, visit www.caremark.com, sign on, and click Prescriptions and Coverage. Or contact Customer Care at 1-800-772-2301.

Out-of-Pocket Maximums

If you use CVS Caremark Mail Service, you'll be protected by a $1,000 individual or $2,000 family out-of-pocket maximum. However, there's no out-of-pocket maximum for retail pharmacy purchases.

Prescription Drug Coordination of Benefits

The prescription drug benefit under the Plan does not coordinate with other plans. The Plan provides primary payment only and does not issue detailed receipts for submission to other carriers for secondary coverage. If another insurance company, plan, or program pays your prescription benefit first, there will be no payments made under the Plan. Because the Plan does not have a coordination of benefits provision for prescription drugs, you may not submit claims to CVS Caremark for reimbursement after any other payer has paid primary or has made the initial payment for the covered drugs.

If you or a covered dependent is covered under this Plan and Medicaid or other similar state programs for prescription drugs, in most instances, your prescription drug coverage under the Plan is your primary drug coverage. You should purchase your prescription drugs using your CVS Caremark ID card and submit out-of-pocket copay expenses to Medicaid or other similar state programs.

Claims and Appeals

Filing a prescription drug claim

Urgent care claims

If the Plan requires preauthorization to receive benefits and a faster decision is required in order to avoid seriously jeopardizing the life or health of the claimant, fax your request to 1-888-836-0730.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the Plan requires preauthorization in order to receive benefits, fax your pre-service claim request to 1-888-836-0730.

Post-service claims

You will need to file a claim if you buy prescription drugs or other covered supplies from a pharmacy not in the CVS Caremark network or if your network pharmacy was unable to submit the claim successfully. All claims must be received by CVS Caremark within one year from the date the prescription drug or covered supplies were dispensed.

Your out-of-network claim will be processed faster if you follow the correct procedures. Complete the Prescription Drug Reimbursement form and send it with the original prescription receipts. You may not use cash register receipts or container labels from prescription drugs purchased at an out-of-network pharmacy.

Prescription drug bills must provide the following information:

- Patient's full name
- Prescription number and name of medication
- Charge and date for each item purchased
- Quantity of medication
- Doctor's name

To get a claim form:

- Go to www.caremark.com, sign on, click Forms & Tools, and download the claim form.
- Call Customer Care at 1-800-772-2301 to request a form.

Send your claim to:

CVS Caremark
PO Box 52196
Phoenix, AZ 85072

You are responsible for any charges incurred but not covered by the plan.

Please refer to "Appendix A: Claims and Appeals" in your *Benefits Book* for more information regarding claims.

CVS Caremark claims questions, denied coverage, and appeals

If you have a question or concern about a claim already filed with CVS Caremark, you may informally contact Customer Care before requesting a formal appeal.

You may also file a formal written appeal to CVS Caremark without first informally contacting Customer Care. A written appeal must be filed within 180 days from the date of the receipt of the initial denial regardless of any verbal discussions that have occurred regarding your claim.

See "Appendix A: Claims and Appeals" in your *Benefits Book*.

Other Things You Should Know

Protecting your safety

The risks associated with drug-to-drug interactions and drug allergies can be very serious. To protect your safety — whether you use CVS Caremark Mail Service or a participating retail pharmacy — CVS Caremark checks for potential interactions and allergies. CVS Caremark also sends this information electronically to participating retail pharmacies.

CVS Caremark may contact your doctor about your prescription

CVS Caremark can dispense a prescription only as it is written by a physician or other lawful prescriber (as applicable to CVS Caremark). Unless you or your doctor specifies otherwise, CVS Caremark dispenses your prescription with the generic equivalent when available and if permissible by law (as applicable to CVS Caremark).

You are not limited to prescriptions on CVS Caremark's primary preferred drug list, but you will probably pay less if you choose a drug from that list. If your doctor prescribes a drug that is not on the primary preferred drug list but there's an alternative on the list, CVS Caremark may contact your doctor to see if that drug would work for you. However, your doctor always makes the final decision regarding your prescriptions. If your doctor agrees to use a preferred drug, you will never pay more than you would have for the original prescription, and will usually save money.

Prescription drug rebates

CVS Caremark administers the prescription drug benefit on behalf of Wells Fargo, but because this Plan is self-insured, all claims are paid by the company through our claims and prescription drug administrators.

Drug manufacturers offer rebates for certain brand-name medications, the majority of which are on the primary preferred drug list. If you purchase a rebate-eligible drug at a participating retail pharmacy or through CVS Caremark Mail Service, a portion of the rebate is passed on to you automatically at the point of sale. The portion of the rebate passed on to you corresponds to your cost share of the drug. The portion passed on to Wells Fargo corresponds to the cost share of the drug paid for by Wells Fargo. Any rebates received by Wells Fargo are applied to the Company's cost of providing and administering health care benefits.

Chapter 4

Mental Health and Substance Abuse Benefits

If you enroll in this Plan, you and your covered dependents are eligible for mental health and substance abuse benefits through OptumHealth Behavioral Services (OHBS). You pay a lesser percentage of mental health and substance abuse charges when you use an OHBS network provider. You pay a greater percentage of the charges when you use an out-of-network provider. Out-of-network benefits are determined by OHBS allowed amounts, and you will be responsible for any amount over the eligible allowed amount. The Plan's mental health and substance abuse benefits are available for inpatient and outpatient care.

For more information about the benefits available to you, see "Chapter 2: Mental Health and Substance Abuse Benefits" in your *Benefits Book*.

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Appendix A
Forms

Please note that the forms in this appendix are not accessible to our visually impaired team members. For assistance with claim forms, please contact your health plan. For assistance with appeal forms, please call 1-877-HRWELLS.

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Wells Fargo & Company Group Health Plan Appeal

Complete this form to file a valid second-level appeal with Wells Fargo Corporate Benefits for the Wells Fargo self-insured group health plans after the Medical, Dental, or Vision claims administrator has issued a determination to your first-level appeal (preservice or postservice). For this form to be considered a valid appeal, all fields of the form must be completed, the form must be signed and dated by the adult patient or parent/legal guardian of a minor child, and the form must be submitted by U.S. mail to Wells Fargo Corporate Benefits with supporting documentation within the allowed time frame for submission of an appeal. If the appeal is not filed per the terms of the plan, it will not be reviewed. Complete information on the appeals process is included in the Summary Plan Description for your plan.

Employee Information (please print legibly)

Employee's Name	Wells Fargo Employee ID Number	Employee's Date of Birth
Wells Fargo Health Plan Name	Doctor, Dentist, or Facility that Provided Service(s)	
Patient's Name	Patient's Date of Birth	Date(s) of Service(s)

Explain what you are appealing and the reason(s) for your appeal (or attach a letter of explanation to this completed form — if you submit a letter of appeal, you must also submit this completed form):

Any information that you want to be considered for your appeal must be submitted with this appeal form. Because the Wells Fargo Corporate Benefits appeal review is independent of any review previously conducted by the claims administrator, *Wells Fargo Corporate Benefits does not have any information that you or your doctor may have previously submitted to the claims administrator.* Be sure to submit with this form pertinent health information from your health care providers and any additional information that you believe supports your appeal, including:

- Relevant patient history (including chart notes and reports from your physician or dentist with documented symptomology, testing results, treatments, etc.)
- Diagnosis and prognosis
- Reason for this treatment option or procedure
- For spending account plans, submit copy of your claim form and supporting expense documentation
- Other health information that supports your request for coverage
- Operative report, if the procedure in question is a surgical procedure
- Explanation of Benefits Statement(s)
- Authorization notices received by you or your physician

Submit typewritten — rather than handwritten — records from physicians and dentists to ensure legibility. Wells Fargo does not reimburse fees that may be associated with obtaining information to be reviewed in support of your appeal. Even if you submit all pertinent information, there is no guarantee that your request will be approved. Lack of adequate documentation to support your request, however, can result in denial of the request due to insufficient evidence. Please keep copies of all documentation you submit; no items will be returned to you.

Informed Consent and Authorization for Use, Release, and Disclosure of Health Information

I hereby authorize my health care providers or their associates and the claims administrator to release health or other information about me (including but not limited to diagnosis, relevant health history, other relevant health information, prognosis, chart notes and reports, services provided, dates of services, billing, claims processing, and payment information) relating to this issue to Wells Fargo Corporate Benefits to allow them to give full and thorough consideration to my appeal request. I understand that this information will be used only for the purpose of obtaining a determination to my appeal request. This authorization also grants the sharing of information between Wells Fargo Corporate Benefits and an independent reviewer if warranted, as determined by Wells Fargo Corporate Benefits, and the claims administrator in the appeal process. This authorization is valid until a determination is issued by the plan administrator. A copy or facsimile of this authorization is valid in lieu of the original. By signing below, I acknowledge and agree to the above Informed Consent and Authorization for Use, Release, and Disclosure of Health Information.

Patient's Signature Date

Signature of Parent or Legal Guardian of Minor Child Relationship to Patient

To protect the confidentiality of your health information, if you wish for someone to represent you in the appeal process, you must complete a *Wells Fargo Authorization for Representation in the Appeal Process* form and submit it with your completed *Wells Fargo & Company Group Health Plan Appeal* form.

HMOs and Other Insured Medical, Dental, or Vision Plans

For an HMO or insured plan, follow the appeal and grievance process noted within the Member Handbook or Certificate of Coverage applicable to the plan. Wells Fargo Corporate Benefits does not have the authority to render determinations on claim issues for the insured plans. All levels of appeal and grievance consideration are reviewed by the HMO/insured plan claims administrator.

Self-Insured Medical, Dental, or Vision Plans

For the following plans, file first-level appeals with the claims administrator.

Plans for Team Members and Retirees Who Are Not Yet Eligible for Medicare	Plans for Medicare-Eligible Retirees
UnitedHealthcare PPO Plan	UnitedHealthcare – Medicare Supplement
Aetna EPO Plan	Aetna Medicare Supplement Plans
Aetna High Option Plan	Prescription Drug Program administered by CVS Caremark
Anthem Blue Cross Blue Shield PPO Plan	Wells Fargo Financial Medicare Supplement Plan
UnitedHealthcare Consumer Directed Health Plan	Retirement Medical Account
HSA High Deductible Health Plan	
HealthPartners Distinctions II Plan	
Prescription Drug Program administered by Medco	
Prescription Drug Program administered by CVS Caremark	
Wells Fargo Dental Plan (Delta Dental option(s) only)	
Mental Health and Substance Abuse Plan administered by OptumHealth Behavioral Solutions	
EyeMed Vision Plan	
UnitedHealthcare Vision Plan	
Vision Service Plan (VSP)	
Flexible Spending Accounts Plan	
Retirement Medical Account	

Complete information on the appeals process is included in the Summary Plan Description for your plan. Refer to the Summary Plan Description for the required information and address for first-level appeal submissions. The claims administrator must receive your first-level appeal within 180 days of the date on which your claim was initially processed (or the date of a denial for preauthorization).

If you have completed the first-level appeal process and are dissatisfied with the determination, you may then file your second-level appeal (or, in the case of the Day Care Flexible Spending Account, your second-level request for review) to Wells Fargo Corporate Benefits for consideration. (*Exception*: There is no second-level appeal for urgent claims.) Complete the appeal form and attach supporting documentation. Send your written second-level appeal (or, in the case of the Day Care Flexible Spending Account, your second-level request for review) to Wells Fargo Corporate Benefits by U.S. mail or overnight delivery service, such as FedEx or UPS, within 90 days from the date on which the claims administrator denied your first appeal to the address noted below. The appeal process is a written process. A verbal request for reconsideration is not a valid appeal.

Second-level appeals must be submitted by U.S. mail, or overnight delivery service, such as FedEx or UPS to:

Wells Fargo Corporate Benefits
Health Plan Appeals
MAC N9311-170
625 Marquette Ave.
Minneapolis, MN 55479

Authorization for Representation in the Appeal Process

To protect the confidentiality of your health information, you'll need to submit this notarized form, along with the completed and signed Wells Fargo Group Health Plan Appeal form to authorize someone to represent you in the second-level group health plan appeal process conducted by Wells Fargo Corporate Benefits on behalf of the plan administrator. This authorization must be completed by the adult patient, the parent or legal guardian of a minor child, or the legal personal representative of the patient (such as Power of Attorney, conservator, executor) in which case, copies of the legal documents must also be presented with this request.

All Plan provisions apply and it is my responsibility to inform the Authorized Representative of the Plan provisions. If my Authorized Representative or I do not comply with the claim appeal provisions of the Plan, I understand that I may lose my right to appeal. I acknowledge that it is my or my Authorized Representative's responsibility to present any information we wish to have reviewed in support of the appeal.

I _____ (print your name) name the following individual as my Authorized Representative:

_____
Authorized Representative's Name

_____
Authorized Representative's Address

in the second-level appeal process for services provided to _____ (Patient Name) on

_____ (Date of Service) by _____
(Doctor, Dentist, or Facility name)

The Authorized Representative may disclose any information related to the appeal issue (including but not limited to diagnosis, relevant health history, other relevant health information, prognosis, chart notes and reports, services provided, dates of services, billing, claims processing and payment information) to Wells Fargo Corporate Benefits. Wells Fargo Corporate Benefits may contact my Authorized Representative for clarification of information presented, if needed. Wells Fargo Corporate Benefits may release the written appeal determination letter to my Authorized Representative and may also release any relevant appeal documentation in its possession to my Authorized Representative upon written request by the Authorized Representative. The written request must be specific with regard to what is being requested, and must be received by Wells Fargo Corporate Benefits Health Plan Appeals by U.S. Mail at the address noted below.

This authorization is only applicable to the appeal issue identified above (and in more detail on the accompanying appeal form). I understand that once my protected health information is disclosed pursuant to this Authorization, the federal privacy protection will no longer apply to information released to the Authorized Representative; Wells Fargo is held harmless for any re-disclosure by my Authorized Representative or his/her failure to protect the information received. The authorization is no longer valid one year after the appeal determination is issued by Wells Fargo Corporate Benefits, on behalf of the plan administrator. However, the authorization may be revoked by me at any time. A written statement of revocation must be submitted in writing by U.S. Mail to :

Wells Fargo Corporate Benefits • Health Plan Appeals, N9311-170 • 625 Marquette Ave • Minneapolis, MN 55479

The revocation will be applicable the date following the date the written revocation is received by Wells Fargo Corporate Benefits Health Plan Appeals via U.S. Mail. The revocation will only be applicable to the extent that information has not already been released or requested based on this Authorization.

I understand and agree to the above stated terms.

_____ _____
Patient's Signature Date of Signature

_____ _____
Signature of Parent or Legal Guardian (of minor child) Or Other Authorized Representative (POA, Executor, etc.) Relationship to Patient

Notary Stamp and Signature (Required):

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Subscriber Submitted Claim

Anthem

One patient and one provider per claim form. See reverse side for claim filing instructions.

1. Identification no.	2. Group no.	
3. Patient name *(Last, First, M.I.) (Please print)*	4. Patient birthdate	5. Patient sex ☐ Male ☐ Female
6. Patient relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	7. Subscriber Name *(Last, First, M.I.) (Please print)*	
8. Subscriber address *(Street, City, State, ZIP code)*		

COORDINATION OF BENEFITS INFORMATION – ANSWER "YES" OR "NO" TO ALL QUESTIONS

9. Were these services required as a result of a job-related illness or accident? ☐ Yes ☐ No ***(If no go to question 10)***		
9a. Name and address of employer	9b. Name and address of compensation carrier	9c. Date of accident
10. Were services required for a condition resulting from an accident or injury caused by another party? ***(If no go to question 11)*** ☐ Yes ☐ No		10a. Date of accident or injury
11. Is patient covered by any other group health benefit plan? ☐ Yes ☐ No ***(If no go to question 12)***		
11a. Name of policyholder	11b. Name and address of insurance company	11c. Policy no.
12. Were services required due to an automobile accident? ☐ Yes ☐ No ***(If no go to question 13)***		
12a. Name and address of automobile insurance company		12b. Date of accident
13. Is patient Eligible for Part A and/or Part B Medicare? ***(If no go to question 14)***	Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No	13a. Medicare no.
14. Illness or symptoms – for reimbursement		
15. Name of provider or hospital facility of service	16. If place of service was outpatient hospital, provide name of hospital facility	
18. If we have questions, who may we contact? Name:	Phone no.	

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

19. Date of service	20. Place of service*	21. Charge for service	22. Briefly describe the service(s) you received

23. Total charges for which you are requesting consideration of payment $	** Place of service* *O = Office* *OP = Outpatient Hospital* *IP = Inpatient Hospital* *L = Lab* *H = Home* *NH = Nursing home* *P = Pharmacy*

24. I certify to the accuracy and completeness of all information reported by me on this form and authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

Full signature and date required on each form incomplete forms may delay processing.

Please ensure all fields are answered.

11004CEMEN 7/09

SUBSCRIBER CLAIM FILING INFORMATION *(HOW TO FILE)*
THIS FORM SHOULD BE USED FOR NON-PARTICIPATING PROVIDERS

Be sure to ask your provider of care if he/she bills a statement to Anthem Blue Cross and Blue Shield. Please submit statements only if the provider does not bill us directly. To receive benefits for services by a provider who does not bill us directly, complete the claim form, attach itemized bills, and confirm the address where your claim should sent by contacting Anthem Blue Cross and Blue Shield Customer Service at 866-418-7749.

Keep a duplicate copy of your itemized bills as they will not be returned to you. This claim may be returned to you if all required information is not present.

CLAIM FILING INSTRUCTIONS *(CORRESPONDS TO NUMBERED ITEMS ON CLAIM FORM)*

A separate claim form must be submitted.

ITEM NO.

1–8	Please complete all blocks. All fields required.
14	Statement of why these services were required.
15	Indicate the name of the physician, hospital or other institutional facility who has billed for services provided to the patient. **Only one provider per form.**
16	If laboratory or radiology services are being billed by a professional provider, and the place of service was inpatient or outpatient hospital, indicate the name of the hospital.
18	Name and telephone number; whoever can help us if additional information is required.
19	Use a separate line for each date of service and receipt.
20	Write the appropriate code to indicate the place of service by using the legend below this section.
22	Briefly indicate the type of service. i.e. lab, x-ray, surgery, therapy, cast, stitches, etc.
23	This amount represents the total of all charges to be considered for benefit.
24	Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

REQUIRED INFORMATION

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

HELPFUL HINTS

- If you have questions or need assistance, contact Anthem Blue Cross and Blue Shield Customer Service.
- To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8 1/2 x 11 piece of paper.
- We encourage you to file claims within 90 days of the service date. Please refer to your Summary Plan Description for specific timely filing limitations.
- File only if the provider has not.

Important: If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider.

A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the Summary Plan Description. Final interpretation of any and all provisions of the program is governed by the Summary Plan Description.

MAIL SERVICE ORDER FORM

Please fold here

Please fold here

Mail order form to:

CVS CAREMARK
PO BOX 94467
PALATINE IL 60094-4467

MTP STD

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. **# of new prescriptions:**

To order refills: Order by Web, phone, or write in Rx number(s) below. **# of refill prescriptions:**
FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

Please fold here

Please fold here

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE:

Last Name

First Name

MI

Suffix (JR, SR)

Street Address

Apt./Suite#

○ **Use this address for this order only.**

City

State

ZIP Code

Daytime Phone #: - -

Evening Phone #: - -

REFILL INFORMATION:

To order mail service refills, enter your prescription number(s) here:

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

Prescriptions sent in one envelope may be shipped together unless you request otherwise.

FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER

1st PERSON ORDERING A PRESCRIPTION

○ Easy open caps ○ Print in Spanish

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ○ M F Date of Birth: MM-DD-YYYY

Your E-mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

2nd PERSON ORDERING A PRESCRIPTION

○ Easy open caps ○ Print in Spanish

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ○ M F Date of Birth: MM-DD-YYYY

Your E-mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

Special Instructions: _____

Please fold here

PAYMENT INFORMATION: Select one payment method below.

○ Electronic Check Processing (Please pre-register at Caremark.com or call Customer Care)

○ Bill Me Later® (Subject to credit approval. Please pre-register at Caremark.com or call Customer Care)

○ Credit/Debit Card (VISA, MasterCard, Discover or American Express)

○ **Charge most recently used credit card**

Charge new/updated credit/debit card (provide info below)

CREDIT CARD# _____ Exp. Date MMYY

Credit Card Holder Signature/Date

○ Check/Money Order: Amount $ ____ . __

Make check or money order payable to CVS Caremark and write your ID# on the check/money order. Returned checks will be subject to a fee of up to $40, depending on state law.

The selected payment method (unless paying by check) will be charged for future orders, unless a different form of payment is provided. It will also be charged for any outstanding balance due.

○ Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

REGULAR DELIVERY IS FREE
(Allow up to 10 days for delivery)

Fill in oval for faster delivery:

○ 2nd Business Day $17 per order

○ Next Business Day $23 per order
(Charges subject to change)

Faster delivery options only affect shipping time, not processing time and can only be sent to a street address, not a P.O. box.

TMM200905134 (12/09)