

Summary Plan Description

Anthem Blue Cross Blue Shield PPO Plan

Effective January 1, 2011

Together we'll go far



Anthem Blue Cross Blue (BCBS) Shield PPO Plan

Contents

Contacts	1
Chapter 1: Administrative information	3
The basics	3
Who's eligible	3
Plan information	3
Chapter 2: Anthem Blue Cross Blue Shield PPO Plan.....	5
How the Plan works	5
Notification requirements.....	7
Special plan features	9
Benefits charts.....	10
General exclusions	38
Claims and appeals.....	41
Coordination with other coverage.....	42
Right of recovery	42
Reimbursement and subrogation.....	43
Chapter 3: Prescription drug benefit.....	45
The basics	45
What's covered.....	46
Your ID card.....	49
CVS Caremark Specialty Pharmacy.....	49
Some prescriptions may require prior authorization.....	49
Prescriptions that are not covered.....	50
Out-of-pocket maximums	51
Prescription drug coordination of benefits.....	51
Claims and appeals.....	51
Other things you should know.....	52
Chapter 4: Mental health and substance abuse benefits.....	55
Mental health and substance abuse benefits.....	57
What is not covered.....	58
Claims and appeals.....	59

Page intentionally left blank

Contacts

Questions about the Anthem BCBS PPO Plan	<p>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.</p> <p>Monday – Friday: 7:00 a.m. – 7:00 p.m. Central Time</p>
Customer Service telephone number	Claims administrator: 1-866-418-7749
Anthem Blue Cross Blue Shield website	<p>anthem.com</p> <p>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.</p>
Information about premiums for the Anthem BCBS PPO Plan	Check your enrollment materials, or go to <i>Teamworks</i> .
Coverage while traveling phone number	<p>1-800-810-BLUE (2583)</p> <p>Use this number to locate BlueCard PPO providers nationwide.</p> <p>For the highest level of benefits, you must use a BlueCard PPO provider.</p>
Medical and behavioral health claims administrator's mailing address	<p>Claims review requests and written inquiries may be mailed to the address below:</p> <p>Anthem Blue Cross Blue Shield PO Box 37010 Louisville, KY 40233</p> <p>Prior authorization requests should be mailed to the following address:</p> <p>Anthem UM Services, Inc. PO Box 7101 Indianapolis, IN 46207</p>
Information about the prescription drug benefit	<p>CVS Caremark 1-800-772-2301 caremark.com</p> <p><i>Note: When accessing prescription drug benefits, you must use your CVS Caremark ID card.</i></p>
24/7 NurseLine	<p>1-866-220-4849</p> <p>Members can receive one-on-one counseling with experienced Anthem nurses.</p>
Information about mental health or substance abuse	<p>Anthem BCBS Behavioral Health 1-866-621-0554</p> <p>Employee Assistance Consulting 1-888-327-0027</p> <p>For TDD access for persons with hearing impairments, please call 1-877-411-0826.</p>

Page intentionally left blank

Chapter 1

Administrative information

The basics

This Summary Plan Description (SPD) covers the provisions of the Anthem Blue Cross Blue Shield (BCBS) 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 their eligible dependents. Participation in the 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.

In case of any conflict between the SPD, any other information provided, and the official Plan document, the Plan document governs Plan administration and benefits 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.

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 the treatment and care you receive.

Responsibilities of covered persons

Each covered team member 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. The SPD includes this booklet, the first chapter and the appendixes of your *Benefits Book*. The *Benefits Book* and SPDs are available on *Teamworks* at work and at home. 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 the 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 the Plan. For more information regarding employment classification and eligibility, refer to “Chapter 1: An introduction to your benefits” in your *Benefits Book*.

Plan information

Claims administrator

Anthem Blue Cross and Blue Shield (“Anthem BCBS”) is the organization designated by the plan administrator to receive, process, and administer claims for benefits described in Chapter 2 of this SPD and make claim payments for such benefits on behalf of the Plan. Anthem BCBS is the claims fiduciary for claims for benefits described in Chapter 2 of this SPD.

CVS Caremark is the organization designated by the plan administrator to receive, process, and administer claims for prescription drug benefits described in Chapter 3 of this SPD and make claim payments for such benefits on behalf of the Plan. CVS Caremark is the claims fiduciary for claims for prescription drug benefits described in Chapter 3 of this SPD.

Anthem Behavioral Health is the organization designated by the plan administrator to receive, process, and administer claims for mental health and substance abuse benefits described in Chapter 4 of this SPD and make claim payments for such benefits on behalf of the Plan. Anthem Behavioral Health is the claims fiduciary for claims for mental health and substance abuse benefits described in Chapter 4 of this SPD.

Anthem BCBS, CVS Caremark, and Anthem Behavioral Health are not the administrators for appeals related to rescission of coverage. Wells Fargo Corporate Benefits has the discretionary authority to determine whether medical coverage will be rescinded (retroactively canceled). Please see “Appendix A: Claims and appeals” of the *Benefits Book* for more details.

Contact information for each of the claims administrators is provided below:

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

1-866-418-7749
1-866-621-0554 (mental health and substance abuse)

Note: The address above also applies for mental health and substance abuse claims.

CVS Caremark
PO Box 52196
Phoenix, AZ 85072

1-800-772-2301

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 (BCBS) PPO Plan coverage option under the Wells Fargo Health Plan for benefits effective January 1, 2011.

The Plan, financed and administered by Wells Fargo & Company, is a self-insured medical plan. Anthem BCBS is the claims administrator and provides administrative services for the medical benefits described in this chapter only. Anthem BCBS 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 BCBS organization(s) in the state in which services are rendered.

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. BlueCard PPO physical therapists, durable medical equipment, chiropractors, acupuncture and labs use base contracted rates and then default to Maximum Benefit Allowed (MBA) if procedure codes are not in their contracts for these providers. Anthem BCBS prices claims using the Maximum Benefit Allowed (MBA) amounts. Pricing is based on 199% of Medicare.
- File claims for you.

For information about the benefits available through these providers, refer to the “[Benefits charts](#)” starting on page 10. To identify providers who participate in the BlueCard PPO network, access the Provider Directory Service through *Teamworks* or at geoaccess.com/directoriestonline/wf.

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 (different rules may apply for emergency services). 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 charts](#)” starting on page 10.

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 (different rules may apply for emergency services). 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. The difference between the out-of-network provider’s charges and the allowed amount is not applied toward the deductible, coinsurance amounts, or out-of-pocket maximum and is your responsibility. This applies to all out-of-network

services described in this SPD. Out-of-network 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 charts](#)” starting on page 10.

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. The difference between the out-of-network provider’s charges and the allowed amount is not applied toward the deductible, coinsurance amounts, or out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this SPD.

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 Anthem BCBS, 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 Anthem BCBS

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, Anthem BCBS 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 the 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

Anthem'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

Anthem BCBS reviews services to verify that they are medically necessary as defined by the Plan (see the "[What the Plan covers](#)" section on page 11) 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 Anthem BCBS is required before you receive selected services.

It is your responsibility to determine whether your provider will obtain prior authorization for you. If you receive services from a BlueCard PPO provider, in most cases, prior authorization will be obtained 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. For pre-service prior authorization, contact Anthem BCBS at 1-866-418-7749 or by fax at 317-287-5049 or 1-800-773-7797. Anthem BCBS 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. Anthem BCBS 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.

The 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 Anthem BCBS 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
- 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 by a medical professional 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 exceeding \$1,000 and certain supplies, prosthetics, or devices exceeding \$1,000, including but not limited to:
 - Motorized wheelchairs: special sized, motorized or powered, and accessories
 - Hospital beds, rocking beds, and air beds
 - Electronic or externally powered prosthetics
 - Custom-made orthotics and braces
- Gender reassignment surgery
- 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 exceeding \$1,000 (except for Emergency Services)
- 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 Anthem BCBS. Please submit your request using the information provided in the “[Contacts](#)” section on page 1.

Preadmissions certification

Preadmissions certification is required at least five days before being admitted for inpatient care for any type of nonemergency service. With preadmissions certification, the Plan guarantees payment for days or services that Anthem BCBS 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. If you receive nonemergency care from out-of-network providers, you are responsible for providing preadmissions certification to Anthem BCBS, if your provider does not provide this service for you.

Preadmissions certification is required for the following facilities:

- Hospitals
 - Acute care admissions
 - Elective admissions
 - Newborn stays following discharge of the mother
 - Obstetric-related admissions other than childbirth
 - Rehabilitation admissions
- Skilled nursing facilities
- Long-term acute care facilities

To obtain preadmissions certification, call the Customer Service number provided in the “[Contacts](#)” section on page 1. They will direct your call.

Emergency admission notification

For inpatient admissions, you are responsible for ensuring that Anthem BCBS is notified of your emergency hospital admission within two business days, if reasonably possible.

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 Anthem BCBS within two business days (if reasonably possible), when you use an out-of-network provider and if your provider does not provide this service for you.

The Plan pays only for services that Anthem BCBS determines are medically necessary as defined by the Plan (see the “[What the Plan covers](#)” section on page 11). To provide emergency admission notification, call the Customer Service number provided in the “[Contacts](#)” section on page 1. 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 for 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 charts

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 (special rules apply for out-of-network emergency services). 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 on page 11).

Your costs at a glance

Benefit features	BlueCard PPO providers	Out-of-network benefits
<ul style="list-style-type: none"> Office visits coinsurance; maximum visits apply to some service categories 	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.
<ul style="list-style-type: none"> Preventive care 	Plan pays 100% for qualifying preventive care services, based on annual exam schedule.	You pay 40%; no deductible.
<ul style="list-style-type: none"> Urgent care Emergency room (ER) — must meet Anthem BCBS emergency care criteria 	<p>You pay 20% after you satisfy the deductible.</p> <p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p> <p>You pay 20% after you satisfy the deductible.</p>
<ul style="list-style-type: none"> Hospital and outpatient care: <ul style="list-style-type: none"> 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.
Annual 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.

* Expenses paid by a participant toward covered medical services described in [“Chapter 2: Anthem Blue Cross Blue Shield PPO Plan”](#) starting on page 5 and covered mental health and substance abuse services described in [“Chapter 4: Mental health and substance abuse benefits”](#) starting on page 55 are applied toward the Plan’s annual deductible and annual out-of-pocket maximums. Expenses paid by a participant toward covered prescription drugs described in [“Chapter 3: Prescription drug benefit”](#) starting on page 45 are not applied toward the Plan’s annual deductible and annual out-of-pocket maximums.

Benefit features	Limitations and maximums
<p>Annual out-of-pocket maximums*</p> <ul style="list-style-type: none"> BlueCard PPO providers Excludes out-of-network deductible, out-of-network coinsurance amounts, and mail-order or retail prescription drug expenses 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 	<p>\$2,300, including deductible, per person per calendar year \$4,600, including deductible, per family per calendar year</p> <p>\$4,400, including deductible, per person per calendar year \$8,800, including deductible, per family per calendar year</p>
<p>Lifetime Maximum</p> <ul style="list-style-type: none"> Infertility services Total benefits paid to all providers combined 	<p>\$10,000 lifetime maximum benefit per person (see the “Infertility and fertility” section on page 22)</p> <p>No maximum (except for infertility services)</p>

* Expenses paid by a participant toward covered medical services described in [“Chapter 2: Anthem Blue Cross Blue Shield PPO Plan”](#) starting on page 5 and covered mental health and substance abuse services described in [“Chapter 4: Mental health and substance abuse benefits”](#) starting on page 55 are applied toward the Plan’s annual deductible and annual out-of-pocket maximums. Expenses paid by a participant toward covered prescription drugs described in [“Chapter 3: Prescription drug benefit”](#) starting on page 45 are not applied toward the Plan’s annual deductible and annual out-of-pocket maximums.

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 benefits 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 licensure 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 or injury. Air ambulance is covered only when the medical condition warrants such transportation due to distance involved or because the patient has an unstable condition requiring medical supervision and more rapid transport.	You pay 20% after you satisfy the deductible.	You pay 20% after you satisfy the deductible.
Medically necessary and prearranged scheduled air or ground ambulance transportation ordered by an attending physician to the next nearest medical facility for tests or care required when those tests or care cannot be provided at the medical facility where the patient is currently located. Air ambulance is covered only when the medical condition warrants more rapid transportation than provided by ground ambulance.	You pay 20% after you satisfy the deductible.	You pay 20% after you satisfy the deductible.

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 on page 38.

Bariatric surgery

The Plan covers	BlueCard PPO providers	Out-of-network providers
<p>Medically necessary inpatient hospital or facility services for bariatric surgery preauthorized by Anthem BCBS:</p> <ul style="list-style-type: none"> • 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 	<p>You pay 20% after you satisfy the deductible when you use Blue Distinction Centers for Bariatric Surgery.</p> <p>No coverage for any other BlueCard PPO provider.</p>	No coverage.
<p>Medically necessary outpatient hospital or facility services for bariatric surgery preauthorized by Anthem BCBS:</p> <ul style="list-style-type: none"> • Scheduled surgery or anesthesia • Lab and diagnostic imaging • All other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery 	<p>You pay 20% after you satisfy the deductible when you use Blue Distinction Centers for Bariatric Surgery.</p> <p>No coverage for any other BlueCard PPO provider.</p>	No coverage.

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- Prior authorization is required for bariatric surgery procedures. Anthem BCBS 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, please refer to the [“Transportation and lodging”](#) section on page 36.
- For a list of Blue Distinction Centers for Bariatric Surgery, call Customer Service or visit Anthem BCBS’s website. Refer to the [“Contacts”](#) section on page 1 for information.
- For pre- and postoperative bariatric services, please refer to the [“Hospital inpatient”](#) section on page 20, the [“Hospital outpatient”](#) section on page 21, and the [“Physician services”](#) section on page 30.
- For professional services related to eligible bariatric surgery services, please refer to the [“Physician services”](#) section on page 30.

- 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:

- Removal of excess skin after weight loss, regardless of need, including but not limited to panniculectomy
- Repeat weight loss surgery, defined as any second or subsequent procedure performed, regardless of coverage at the time of the previous procedure
- All other weight loss related services, supplies, or treatments

Chiropractic care

The Plan covers	BlueCard PPO providers	Out-of-network providers
Chiropractic care (26 visits per calendar year maximum)	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.

Other notes:

- Please see the “[Notification requirements](#)” section on page 7.
- 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, in- and out-of-network, 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, 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 on page 38.

Dental care

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 before the child turns 19 • Surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Accident-related dental services, treatment, or restoration of sound natural teeth if services are performed within 12 months of the date of injury. Coverage is limited to the initial treatment (or course of treatment) or initial restoration. Coverage for treatment or restoration is limited to reimplantation of original sound natural teeth and crowns, fillings, and bridges required to restore the sound natural teeth damaged by the accident. 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.
- The Plan covers anesthesia and inpatient and outpatient hospital facility 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 on page 20 or the [“Hospital outpatient”](#) section on page 21. 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. Oral surgeon or dentist professional fees are not covered.
- 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 on page 20, the [“Hospital outpatient”](#) section on page 21, and the [“Physician services”](#) section on page 30.
- 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 that 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 BCBS’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 the 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 not performed within 12 months from the date of injury.
- Any dental procedure or treatment not listed as covered within this SPD.
- Dental services to treat an injury from biting or chewing.
- Dentures, regardless of the cause or the condition, and any associated services or charges, including bone grafts.
- Dental implants and any associated services 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 anomaly and all associated expenses, including hospitalizations and anesthesia, except as noted above.
- Please refer to the “[General exclusions](#)” section on page 38.

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 you satisfy the deductible.	You pay 20% after you satisfy the deductible.
Outpatient health care professional charges	You pay 20% after you satisfy the deductible.	You pay 20% after you satisfy the deductible.

Other notes:

- Please see the “[Notification requirements](#)” section on page 7.
 - When determining if a situation is a medical emergency, Anthem BCBS 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 on page 38.

Home health care

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – Licensed registered nurse – Licensed registered physical therapist – Master’s degree-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 on page 23 • Palliative care 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 on page 24.
- 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 calendar year (combined with extended skilled nursing care and skilled nursing care).
- 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”](#) starting on page 45 for prescription drug coverage information.
- Private duty nursing (see the [“Extended skilled nursing care”](#) section on page 18 for more information).
- Please refer to the [“General exclusions”](#) section on page 38.

Extended skilled nursing care

The Plan covers	BlueCard PPO providers	Out-of-network providers
Extended skilled nursing care	You pay 20% after you satisfy the deductible.	You pay 40% of eligible covered expenses after you satisfy the deductible.

Extended skilled nursing care is defined as the use of skilled nursing services delivered or supervised by a registered nurse (RN) or licensed practical nurse (LPN) to obtain the specified medical outcome and provide for the safety of the patient. To be covered under the Plan:

- An attending physician must order extended skilled nursing care.
- Certification of the RN or LPN providing the care is required.
- The Plan, in its sole discretion, must determine that the extended skilled nursing care is medically necessary.
- The covered person and the provider must obtain prior authorization from the Plan (contact member services of the Plan to request prior authorization).

Coverage is limited to 100 visits per person per calendar year (combined with home health care and skilled nursing care). Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts towards the 100 combined visits. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit towards the 100 visit limitation (combined with home health care and skilled nursing care.)

Services provided under the following circumstances will be considered extended skilled nursing services:

- Transition of the covered person from an inpatient setting to home.
- The covered person becomes acutely ill and the additional skilled nursing care will prevent a hospital admission.
- The covered person meets the clinical criteria for confinement in a skilled nursing facility, but a skilled nursing facility bed is not available. In this situation, additional skilled nursing may be provided until a skilled nursing facility bed becomes available.
- The covered person is on a ventilator or depends on continuous positive airway pressure due to respiratory insufficiency at home.

The following types of care are not covered:

- Nursing care that does not require the education, training, and technical skills of an RN or LPN.
- Nursing care provided for skilled observation.
- Nursing care provided while the covered person is an inpatient in a hospital or health care facility.
- Nursing care to administer routine maintenance medications or oral medications, except where law requires an RN or LPN to administer medicines.
- Custodial care for daily life activities such as but not limited to:
 - Transportation
 - Meal preparation
 - Vital sign charting
 - Companionship activities
 - Bathing
 - Feeding
 - Personal grooming
 - Dressing
 - Toileting
 - Getting in or out of bed or a chair
- Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a nurse to provide unskilled services.

Hospice care

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 on page 38.

Hospital inpatient

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 on page 26.
- 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 on page 15.
- For cardiac care, you have the option of using Blue Distinction Centers for Cardiac Care. Call Customer Service before 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, please see the [“Transportation and lodging”](#) section on page 36.

- For bariatric services, you must use Blue Distinction Centers for Bariatric Surgery. Call Customer Service before 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 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 gender reassignment per 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. (HBI/GDA).
- 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 on page 38.

Hospital outpatient

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 you satisfy the deductible.	You pay 40% after you satisfy the deductible.

Other notes:

- Please see the “[Notification requirements](#)” section on page 7.
- 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 on page 15.
- For cardiac care, you have the option of using Blue Distinction Centers for Cardiac Care. Call Customer Service before 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 before 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.
- 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 on page 38.

Infertility and fertility

The Plan covers	BlueCard PPO providers	Out-of-network providers
(\$10,000 lifetime limit)		
• Infertility diagnosis and treatment	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.
• Artificial insemination	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.
• <i>In vitro</i> fertilization	Not covered	Not covered
• Infertility drugs	Not covered	Not covered

Other notes:

- You must be diagnosed with infertility to be eligible for artificial insemination.
- Charges for or related to infertility services are limited to a lifetime maximum benefit of \$10,000 per person.
- Please see the “[Notification requirements](#)” section on page 7.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Refer to the “[Hospital inpatient](#)” section on page 20 and the “[Hospital outpatient](#)” section on page 21 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.
- Prescription drugs for the treatment of infertility.
- 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), 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.
- Fees for maintenance or storage of sperm, ovum, or frozen embryos.
- Charges related to surrogate pregnancy.
- Services exceeding the lifetime maximum for this benefit.
- Please refer to the “[General exclusions](#)” section on page 38.

Maternity

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • Health care professional office visit services for prenatal and postnatal care • Outpatient hospital or facility charges for prenatal and postpartum care • Inpatient hospital care, including delivery 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 to receive benefits under the Plan. 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 on page 17.
- 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 and maternity benefits.
- Please refer to the [“General exclusions”](#) section on page 38.

Medical equipment, prosthetics, and supplies

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 dependent children up through the calendar year the dependent child turns age 18, limited to one hearing aid or one set of hearing aids every three calendar years • Contact lenses and bandages required after a covered surgical procedure 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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”](#) starting on page 45.
- 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, 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 Anthem’s determination of medically necessary.
- Rental or purchase of manual breast pump 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 or 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.
- Oral or dental prosthesis.
- Please refer to the [“General exclusions”](#) section on page 38.

Nutritionists and nutrition

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • Nutritional counseling • Nutritional formulas 	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.

Nutritionists

After you satisfy the deductible, you pay coinsurance. The Plan will pay for nutritional counseling provided in a physician’s office by an appropriately licensed nutritionist or health care professional when education is required for a disease in which patient self-management is an important component of treatment and there exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional. Some examples of such medical conditions include:

- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

For exceptions, refer to the [“What is not covered”](#) section on page 58.

Nutritional formulas

After you satisfy the deductible, you pay coinsurance. The Plan covers nutritional formulas only when used as the definitive treatment of an inborn metabolic disorder, such as phenylketonuria (PKU).

Not covered:

- Diets for weight control or treatment of obesity (including liquid diets or food)
- Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements (except when used as the definitive treatment of an inborn metabolic disorder, such as PKU)
- Food, food substitutes, or food supplements of any kind (diabetic, low fat, cholesterol, infant formula, etc.)
- Megavitamin and nutrition based therapy
- Nutritional counseling for either individuals or groups except as stated above, including weight loss programs, health clubs, and spa programs
- Oral vitamins and oral minerals

Also, refer to the [“What is not covered”](#) section on page 58.

Organ and bone marrow transplant coverage

The Plan covers	BlueCard PPO providers	Out-of-network providers
<p>The following medically necessary human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – Potential donor testing – Donor evaluation and workup – Hospital and professional services related to organ procurement 	<p>You pay 20% after you satisfy the deductible for covered services received at Blue Distinction Centers for Transplant (BDCT) providers or other participating BlueCard PPO transplant providers.</p> <p>If you live more than 50 miles from a BDCT provider, please see the “Transportation and lodging” section on page 36. Travel and lodging is subject to a \$10,000 lifetime maximum.</p>	<p>No coverage.</p>

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 on page 20 and the “[Physician services](#)” section on page 30.
- 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 BCBS, 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 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 or tissue transplants unless otherwise specified in this SPD.
- Transplantation of animal organs or tissue.

- Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under the Plan.
- Kidney donor expenses when the recipient is not covered for the kidney transplant under the Plan.
- Travel expenses for a kidney donor.
- Additional exclusions are listed in the “[General exclusions](#)” section on page 38.

Definitions:

- **Allowed amount.** For network benefits, it is the rate the claims administrator has agreed by contract to reimburse the Provider for a given service or supply. For out-of-network benefits:
 - Rates negotiated, or otherwise recommended, by a vendor, subcontractor, or affiliate and that may have been agreed to by the out-of-network provider, or
 - The following, alone or in combination:
 - The amount the claims administrator pays other providers (contracted or noncontracted)
 - An amount based on what the Centers for Medicare and Medicaid Services (CMS) pays providers for the same services or supplies
- **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 BCBS 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.

Outpatient surgery and diagnostic and therapeutic services

The Plan covers	BlueCard PPO providers	Out-of-network providers
<p>Outpatient surgery, diagnostic and therapeutic services (includes labs and x-rays)</p> <p>May be performed in a hospital, an outpatient facility, or a doctor's office</p>	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.

The Plan covers services received on an outpatient basis at a hospital or alternate facility, including:

- Diabetes outpatient self-management training and education, including medical nutrition therapy
- Kidney dialysis (both hemodialysis and peritoneal dialysis)
- Lab*
- X-ray[†]
- Mammography testing
- Radiation and chemotherapy
- CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services[†]
- Covered health services, including medical education services that are provided on an outpatient basis by appropriately licensed or registered health care professionals when education is required for a disease in which patient self-management is an important component of treatment and where a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required
- Scheduled surgery, anesthesia, and related services
 - When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
 - Noncontracted assistant surgeon fees in a nonemergency situation are considered at 50% of the allowed fee for the primary surgeon, as determined by Anthem BCBS. The difference between the amount charged and the amount paid by Anthem BCBS is the team member's responsibility.

- Scopic procedures — outpatient diagnostic and therapeutic*
 - Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.
 - Benefits do not include inpatient surgical scopic procedures. Benefits for inpatient surgical scopic procedures are covered in the "[Hospital inpatient](#)" section on page 20.

* When more than one diagnostic procedure is performed within the same diagnostic family on the same day, one procedure will be considered at 100% of the eligible expense and the other procedures will be considered at 50% of the eligible expense.

[†] When more than one diagnostic procedure is performed during the same session, the first procedure will be considered at 100% of the eligible expense, each subsequent procedure will be considered at 50% of the eligible expense.

Physical therapy, occupational therapy, speech therapy

The Plan covers	BlueCard PPO providers	Out-of-network providers
<p>Limited to 90 visits per calendar year, in and out of network, and combined for the following:</p> <ul style="list-style-type: none"> • Rehabilitative physical therapy • Rehabilitative occupational therapy • Rehabilitative speech therapy to restore: <ul style="list-style-type: none"> – Previously attained speech function that has become impaired as a result of a congenital defect for which corrective surgery has been performed – Previously attained speech function that has become impaired as a result of injury or sickness except for a mental or personality disorder • Cardiac rehabilitation therapy • Pulmonary rehabilitation therapy • Habilitative speech therapy provided by a licensed speech therapist to a child member who has failed to acquire the skills expected of a person of the same age as a result of: <ul style="list-style-type: none"> – A development delay – Hearing impairment – Major congenital anomalies that affect speech such as but not limited to cleft lip and cleft palate – Habilitative-related therapies are covered through the end of the year of a participant’s 18th birthday 	<p>You pay 20% after you satisfy the deductible.</p>	<p>You pay 40% after you satisfy the deductible.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 [“Outpatient surgery and diagnostic and therapeutic services”](#) section on page 28. For lab and diagnostic imaging services billed by a facility, please refer to the [“Hospital inpatient”](#) section on page 20 or the [“Hospital outpatient”](#) section on page 21.
- You pay all charges that exceed the allowed amount as determined by Anthem BCBS when you use an out-of-network provider.
- In addition to the limitations noted above, therapies must also meet Anthem BCBS criteria for medical necessity.

Speech therapy is also covered for developmental delay for children through the calendar year in which your child turns age 18.

Example: If your child turns 18 years old on May 17, 2010, he or she will continue to be covered through December 31, 2010.

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, 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 regardless of the underlying cause, except as noted under speech therapy in the table above. Delayed development means the individual has been unable to acquire the skills expected of a person of that particular age.

- Speech therapy that has not been preapproved by Anthem BCBS.
- Speech therapy for voice modulation, articulation, or similar training (including teaching someone to speak another language).
- Speech therapy to treat stuttering, stammering, or the elimination of a lisp.
- Speech therapy except as described above.
- Please refer to the [“General exclusions”](#) section on page 38.

Physician services

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 you satisfy the deductible.	You pay 40% after you satisfy the deductible.
<ul style="list-style-type: none"> • 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 you satisfy the deductible.	You pay 40% after you satisfy the deductible.
<ul style="list-style-type: none"> • Outpatient hospital or facility visits 	You pay 20% after you satisfy the deductible.	You pay 40% after you satisfy the deductible.

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 before 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 before 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 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 on page 38.

Preventive care services

The Plan covers in-network, eligible preventive care services at 100%. When using out-of-network providers, eligible preventive care services are not subject to the out-of-network deductible and you pay 40% of the Anthem BCBS PPO Plan allowed amount.

In order for a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines. Many of the guidelines take into account gender, age, and your or your family's medical history.

Preventive care services for children

As recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics, the types of services for children covered as preventive care services include but are not limited to:

- Well-baby care physical exams
- Well-child care physical exams
- Vision and hearing screenings
- Developmental assessments
- Screening for depression and obesity

Routine vaccines

As recommended by the Center for Disease Control's Advisory Committee on Immunization Practices, the types of routine vaccines covered as preventive care services include but are not limited to:

- Routine childhood immunizations such as diphtheria, tetanus, pertussis, polio, chicken pox, measles, mumps, rubella, hepatitis A and B, pneumococcal, meningococcal, rotavirus, human papillomavirus, flu
- Routine vaccinations for adults such as flu, pneumococcal, tetanus, diphtheria, Zoster

Preventive care services for adults

As recommended by the U.S. Preventive Services Task Force, the types of services covered as preventive care services for adults include but are not limited to the following services that have a current rating of A or B:

- Adult routine physical exams
- Routine screenings such as blood pressure, cholesterol, diabetes
- Routine screenings such as mammography, colonoscopy, pap smear, PSA test

- Routine gynecological exams
- Bone density tests
- Routine prenatal and postnatal care and exams
- Screening for depression and obesity

Your provider will inform the Plan what services you received when the provider submits the claim to the Plan for processing. If the claim is coded as an eligible preventive care service with a routine diagnosis code, the claim will be paid as a preventive care service.

Services not considered preventive care services:

- Services that are not recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines.
- Although recommended by one of several government or independent agencies responsible for the development and monitoring of U.S. preventive care guidelines, services that do not follow the government or independent agency's age, gender, or family history recommended guidelines.
- Services the provider submits to the Plan coded as non-routine, which may include:
 - Office visits, screenings, lab work, tests, or procedures to diagnose a condition, treat a specific illness, or monitor an existing condition.
 - Additional office visits, lab works, tests, or procedures recommended or required as a result of a preventive care visit, lab work, test, or procedure.
 - Office visits, screenings, lab work, tests, or procedures if a condition or diagnosis is detected.
 - Part of the services received that the provider submits to the Plan coded as non-routine (i.e., office visit, lab work, tests, or procedures).

You may be required to pay a copay or coinsurance if you receive eligible preventive care services at the same time you receive certain services that are not considered eligible preventive care services. For example, if you see your provider for a recurring medical problem, but also receive an eligible preventive care service, the provider may submit the claim as a non-preventive care office visit. You would then be responsible for the non-preventive care office visit copay or coinsurance amount. However, the provider may submit separate claims for the preventive and non-preventive services or treatments.

If the primary purpose of your visit is for preventive care services (e.g., an annual physical exam), but you also discuss other health problems during the visit

(e.g., a recurring medical problem), your provider may submit the claim as an eligible preventive care service or the provider may submit separate claims for the preventive and non-preventive services or treatments.

If you have questions about how claims for your office visit, screenings, lab work, tests, or procedures will be submitted to the Plan, talk to your provider about the type of care you receive or are recommended to receive before the claim is submitted to the Plan. Once the claim is submitted to the Plan, the claim will be processed based on how your provider coded the claim (i.e., services coded by your provider as routine services will be processed as routine services).

For additional information on preventive care coverage under the Plan, visit the Plan’s website or call Anthem BCBS PPO Member Services department.

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • Routine cancer screening as specified below: <ul style="list-style-type: none"> – Mammograms – Pap smears – Flexible sigmoidoscopies 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 • Routine immunizations • Osteoporosis screening (radiology services) • Routine lab services as specified below: <ul style="list-style-type: none"> – Cholesterol and lipid profile – Thyroid screening – Diabetes screening – Hemoglobin – CBC – Urinalysis • Screening for chlamydia, gonorrhea, syphilis, and HIV 	<p>Plan pays 100% for eligible routine preventive care services. U.S. Preventive Services Task Force Guidelines are used to determine the frequency for covered health services.</p>	<p>You pay 40%, no deductible, for eligible routine preventive care services. U.S. Preventive Services Task Force Guidelines are used to determine the frequency for covered health services.</p>

Other notes:

- For more information regarding well-child care, please see the the “[Well-child care](#)” section on page 37.
- Please see the “[Notification requirements](#)” section on page 7.
- 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 and eyewear including lenses, frames, and contact lenses and fitting, except where eligible in the “[Medical equipment, prosthetics, and supplies](#)” section on page 24.
- Services obtained for travel.
- Please refer to the exclusions listed in this “Preventive care services” section and to the “[General exclusions](#)” section on page 38.

Reconstructive surgery

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • Reconstructive surgery for prompt repair of accidental injury that occurs while covered under the Plan. • Reconstructive surgery that is incidental to or following surgery resulting from sickness or other diseases of the involved body part. The surgery must be required because the primary physiological function has been impaired due to the disease or illness and the purpose of the surgery is to restore the primary physiological function of the body part on which the surgery will be performed. • 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. 	<p>For the level of coverage, see the “Hospital inpatient” section on page 20, the “Hospital outpatient” section on page 21, and the “Physician services” section on page 30.</p>	<p>For the level of coverage, see the “Hospital inpatient” section on page 20, the “Hospital outpatient” section on page 21, and the “Physician services” section on page 30.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 or charges, including bone grafts.
- Dental implants and any associated services and charges.
- Repair of scars and blemishes on skin surfaces.
- Services related to teeth, the root structure of teeth, or supporting bone and tissue, except as noted in the [“Dental care”](#) section on page 15.
- Please refer to the [“General exclusions”](#) section on page 38.

Skilled nursing facility

The Plan covers	BlueCard PPO providers	Out-of-network providers
<ul style="list-style-type: none"> • 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 you satisfy the deductible.	You pay 40% after you satisfy the deductible.

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- You must use a BlueCard PPO provider to obtain the highest level of coverage.
- Coverage is limited to a maximum benefit of 100 day visits per person per calendar year combined with home health care and extended skilled nursing, up to 24 hours per day, in- and out-of-network.
- 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 (see the [“Extended skilled nursing care”](#) section on page 18 for more information).
- Please refer to the [“General exclusions”](#) section on page 38.

Transportation and lodging

For bariatric surgery, cardiac care, or organ and bone marrow transplants, Anthem BCBS will assist the patient and family with travel and lodging arrangements if the patient meets the criteria to receive services and resides more than 50 miles from a Center of Excellence. The travel benefit is subject to a lifetime maximum of \$10,000.

Lodging

The following daily limits apply for lodging:

- Up to \$50 per day for the patient or the caregiver if the patient is in the hospital.
- Up to \$100 per day for the patient and one caregiver. When a child is the patient, two persons may accompany the child; however, the daily rate for lodging remains at up to \$100 per day.

Transportation

Eligible expenses include:

- Automobile mileage, reimbursed at the standard IRS medical rate. Effective January 1, 2009, the rate is 24 cents per mile.
- Taxi fares are covered; all receipts must be submitted. *Note: Automobile rental and gas are not covered expenses.*
- Economy or coach airfare (anything other than economy or coach airfare is *not* covered)
- Parking
- Trains
- Boat
- Bus
- Tolls

Well-child care

Please see the [“Preventive care services”](#) section on page 32 for additional information.

The Plan covers	BlueCard PPO providers	Out-of-network providers
<p>The following outpatient services for a dependent child from birth to age 18:</p> <ul style="list-style-type: none"> • Preventive services • Routine developmental assessments • Routine laboratory services • Routine immunizations 	<p>Plan pays 100% for eligible well-child care services, based on U.S. Preventive Services Task Force Guidelines.</p>	<p>You pay 40%, no deductible for eligible well-child care services, based on U.S. Preventive Services Task Force Guidelines.</p>

Other notes:

- Please see the [“Notification requirements”](#) section on page 7.
- 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 exclusions listed in the [“Preventive care services”](#) section on page 32 and to the [“General exclusions”](#) section on page 38.

General exclusions

In addition to any other exclusions or limitations specified in this chapter, the Plan does not cover the following:

- 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 that 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. Anthem BCBS bases a decision on an examination of the following reliable evidence, none of which is determinative in and of itself:
 - Any drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition that the administrator or the administrator's designee determines in its sole discretion to be experimental or investigative. The administrator will deem any drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply to be experimental or investigative if the administrator determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply:
 - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted.
 - Has been determined by the FDA to be contraindicated for the specific use.
 - Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply.
 - Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
 - Is provided pursuant to informed consent documents that describe the drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply as experimental or investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply is under evaluation.
 - Any service not deemed experimental or investigative based on the criteria above may still be deemed experimental or investigative by the administrator. In determining whether a service is experimental or investigative, the administrator will consider the information described below and assess whether:
 - The scientific evidence is conclusory concerning the effect of the service on health outcomes.
 - The evidence demonstrates that the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects.
 - The evidence demonstrates that the service has been shown to be beneficial for the total population for whom the service might be proposed as any established alternatives and the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- The information considered or evaluated by the administrator to determine whether a drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply is experimental or

investigative under the above criteria may include one or more items from the following list, which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.
- Documents issued by or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply.
- Documents of an Institutional Review Board (IRB) or other similar body performing substantially the same function.
- Consent document(s) or the written protocol(s) used by the treating physicians, other medical professionals, or facilities, or by other treating physicians, other medical professionals, or facilities studying substantially the same drug, biologic device, diagnostic product, equipment, procedure, treatment, service, or supply.
- Medical records.
- The opinions of consulting providers and other experts in the field.
- 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 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 for or x-ray examinations of 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 or charges, including bone grafts.
- Dental implants and any associated services 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, and requesting a referral, and services that would similarly not be charged for an on-site medical office visit.
- Inpatient hospital room and board expenses that exceed the semiprivate room rate, unless a private room is approved by Anthem BCBS as medically necessary.
- Modifications to home, vehicle, or the workplace, including vehicle lifts and ramps.
- Nonemergency 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.
- Personal comfort items, such as telephone, television, barber and beauty supplies, and guest services.

- Services a provider gives to himself or herself or to a close relative (such as a spouse, brother, sister, parent, grandparent, or child).
- Services for dependents not covered under the Plan.
- Services for or related to:
 - 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 on page 35
 - Dental or oral care, treatment, orthodontics, or surgery and any related supplies, anesthesia, or facility charges, except as specified in the [“Dental care”](#) section on page 15
 - Fetal tissue transplantation
 - Functional capacity evaluations for vocational purposes 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 Anthem BCBS 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 on page 24
 - Lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the [“Medical equipment, prosthetics, and supplies”](#) section on page 24
 - Private-duty nursing (see the [“Extended skilled nursing care”](#) section on page 18 for more information)
 - 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, 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 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 on page 12
- 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
- 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 or 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 on page 26.
- 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 on page 13, the "[Hospital inpatient](#)" section on page 20, and the "[Organ and bone marrow transplant coverage](#)" section on page 26.
- Treatment, equipment, drug, or device that Anthem BCBS determines does not meet generally accepted standards of practice in the medical community for cancer or allergy testing and treatment; services for or related to chelation therapy that Anthem BCBS determines is not medically necessary; services for or related to systemic candidiasis, homeopathy, or immunoaugmentative therapy.

- Treatments, services, or supplies that are not medically necessary, as determined by Anthem BCBS at its discretion. This includes but is not limited to care, supplies, or equipment that does not meet Anthem BCBS'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 that 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 post-service 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 BCBS at 1-866-418-7749 or by fax at 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 BCBS at 1-866-418-7749 or by fax at 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 BCBS 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. 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 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 you 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 BCBS 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 contact member services before filing an appeal. For more information, see the "[Contacts](#)" section on page 1.

You may also file an appeal with Anthem BCBS without first contacting the member service department. An 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. Once you exhaust the internal appeals procedures, you are entitled to an external review of your claim.

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

Coordination with other coverage

When you or your dependents have other group medical insurance (through your spouse's or domestic partner's employer, or Medicare, for example), the Wells Fargo health plan and the other plan may both pay a portion of covered expenses. One plan is primary, the other plan is secondary. This is called coordination of benefits (COB). Please note the following:

- There is no COB between Wells Fargo health plans; only one Wells Fargo health plan will provide coverage for eligible expenses.
- Wells Fargo health plans do not coordinate prescription drug benefits. For example, if you are covered under a Wells Fargo health plan and the other plan is primary, there is no secondary prescription drug benefit under the Wells Fargo health plan.

If the Wells Fargo health plan is secondary, it pays only the difference between the other plan's benefit, if lower, and the normal Wells Fargo health plan benefit. When the primary plan pays a benefit that equals or exceeds the normal Wells Fargo health plan benefit, the Wells Fargo health plan pays nothing.

If you receive benefits from more than one group health plan (or a government-supported program other than Medicaid), the primary payer must process your claim before you can submit it to the secondary payer.

For detailed information regarding coordination of coverage, refer to the "Coordination with other coverage" section in "Chapter 1: An introduction to your benefits" of your *Benefits Book*.

Right of recovery

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

- The persons the Plan paid or for whom the 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

The 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 the Plan arising out of an illness or injury for which a third party is or may be liable, the 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 the Plan to reimburse the Plan for the benefits paid. The Plan will be reimbursed first for 100% of benefits paid by the 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), 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; 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 Anthem BCBS 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 the 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 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, before 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 attorneys’ 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 section to Anthem BCBS.

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 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

Anthem BCBS 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:

- Anthem BCBS 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. You have the right to designate any participating physician who is in the Anthem BCBS network and who is available to accept you or your family. For children, you may designate a participating pediatrician. If you do not make a selection, Anthem BCBS will make 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. To identify providers who participate in the BlueCard PPO network, access the Provider Directory Service through *Teamworks* or at geoaccess.com/directoriesonline/wf.
- Anthem BCBS 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.

Chapter 3

Prescription drug benefit

The basics

CVS Caremark administers the prescription drug benefits offered under the Plan. This means that CVS Caremark administers claims for prescription drug benefits under the Plan. 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 Primary/Preferred Drug List, is covered by the Plan, or is subject to certain Plan provisions, visit [caremark.com](https://www.caremark.com) or call Customer Care at 1-800-772-2301 to obtain information about the 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 Primary/Preferred Drug List 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 on page 49 for more information.

Bring your CVS Caremark ID card and pay your portion, as shown in the "[What you'll pay for prescriptions](#)" table on page 48, 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 on page 49 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](#)" table on page 48, up to a 30-day supply per prescription.

To locate a CVS Caremark participating pharmacy:

- Visit the CVS Caremark website at [caremark.com](https://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. CVS Caremark will process all mail-order prescriptions as they are received if there are eligible refills; prescriptions will not be held to be filled at a future date unless specifically requested.

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 [caremark.com](https://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.

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

For your prescription to be covered, it must meet CVS Caremark's coverage criteria. In addition, all prescriptions are subject to the limitations, exclusions, and procedures described in this SPD. When more than one definition or provision applies, the most restrictive applies and exclusions take precedence over general benefit descriptions.

The following prescription types are generally covered, but some may require prior approval, be limited in the amount you can get at any one time, or be 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, and lancets
- Insulin, insulin pens, insulin prefilled syringes, needles, and syringes for self-administered injections

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 and medications

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, or when you submit prescriptions for multiple insulins or oral diabetic medications, 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 or diabetic medications at a retail pharmacy, separate 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 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	Not applicable	Not applicable	\$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 the 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 copay, 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 on page 49.
- 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. Contact CVS Caremark 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 on page 49.

Your ID card

Shortly after you enroll in the 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 [caremark.com](https://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 are 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
- Access to a pharmacist 24 hours a day, 7 days a week, 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) 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 [24 hours if emergency care] 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.

The lists of drugs that require prior authorization are subject to change at any time as new prescription drugs, generic drugs, or additional information about existing drugs becomes available. Below are some examples of drugs that may require prior authorization:

- Anabolic steroids (e.g., Anadrol-50[®], Winstrol[®], Oxandrolone[®])
- Antimalarial agents (e.g., Quaaluan[®])
- Botulinum toxins (e.g., Botox[®], Myobloc[®])
- Dermatologic agents (e.g., Retin-A, Tazorac[®], Solydyn[®])
- Erythroid stimulants (e.g., Epogen[®], Procrit[®], Aranesp[®])
- Growth stimulating agents (e.g., Genotropin[®], Norditropin[®])
- Immune globulines (e.g., Vivaglobin[®])
- Interferon agents (e.g., Intron[®] A, PegIntron[™], Pegasys[®])
- RSV prevention injections (e.g., Synagis[®])
- Multiple sclerosis therapy (e.g., Avonex[®], Betaseron[®], Copaxone[®])
- Narcolepsy treatments (e.g., Provigil[®])
- Pain management (e.g., Lidoderm[®] patches, Actiq[®], Lyrica[®])
- Cancer treatments (e.g., Gleevec[®], Avastin[®])
- Weight loss drugs (e.g., Meridia[®])
- Other miscellaneous drugs (e.g., Acthar[®] gel, Arcalyst[®], Ilaris[®], Kuvan[®], Solaris[®], Xenazine[®])

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:

- **Allergy medications.** You may need to try generic fexofenadine, fexafenadine, or pseudoephedrine before the Plan will cover Allegra D[®] 24 hour, Clarinex[®], Clarinex D[®], or Xyzal[®].
- **Blood pressure medications.** You may need to try generic benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, quinapril, ramipril, ortrandolapril, or Avapro[®] or Avalide[®], before the Plan will cover other brand-name cardiovascular drugs such as Actacand[®], Benicar[®], Hyzaar[®], Cozaar[®], Diovan[®], Micardis[®], Tekturna[®], or Teveten[®].
- **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 fluticasone 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 Fosamax[®]) or Boniva[®] before the Plan will cover other brand-name osteoporosis medications such as Actonel[®].
- **Pain medications.** You may need to try generic ibuprofen, indomethacin, meloxicam, naproxen, or other generic non-sedating, anti-inflammatory drugs before the Plan will cover other brand-name drugs such as Athrotec[®], Celebrex[®], or Flector[®].
- **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 to 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[®], Vancericil[®])
- Pain medications (such as Actiq[®], Fentora[®], Lyrica[®])
- 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

In addition to any other exclusions or limitations specified in this chapter, the Plan does not cover the following (even if prescribed by a physician):

- 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, 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, unless otherwise approved by CVS Caremark based on clinical criteria as determined by CVS Caremark in its sole discretion.
- Drugs that require administration by a dental professional (e.g., Arrestin[®], PerioChip[®]).
- Investigational or experimental drugs, as determined by CVS Caremark in its discretion.
- Drugs for which the 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 (except as otherwise may be required by applicable federal law).
- 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.
- Prescriptions that do not meet CVS Caremark's coverage criteria.
- Prescriptions that do not meet the Plan's definition of a covered health service.
- 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 or specialty prescriptions that are not filled at a CVS Caremark Mail Service facility or a CVS Caremark Specialty facility.

The following are not covered as prescription drug benefits under the Plan; however, they may be eligible for some level of coverage under the Plan. Please see "[Chapter 2: Anthem Blue Cross Blue Shield PPO Plan](#)" starting on page 5 and contact Anthem BCBS for more information.

- Allergy sera or allergens
- Contraceptive devices and inserts that require fitting or application in a doctor's office, such as a diaphragm, Depo-Provera, or Norplant

- 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

This list is subject to change. To determine if your prescription is covered, visit 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 the 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 [caremark.com](https://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 contact Customer Care before requesting an appeal.

You may also file an appeal with CVS Caremark without first contacting Customer Care. An appeal must be filed within 180 days from the date of receipt of the

initial denial regardless of any verbal discussions that have occurred regarding your claim. Once you exhaust the internal appeals procedures, you are entitled to an external review of your claim.

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

Other things you should know

Drug safety

The risks associated with drug-to-drug interactions and drug allergies can be very serious. 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.

Also, CVS Caremark offers consultative services to help manage chronic or long-term conditions, such as diabetes. These services may help you save on pharmacy costs and may help to prevent related complications or disease progression. Through this program, you and your doctor may be contacted via telephone by a CVS Caremark pharmacist to discuss your therapy and provide condition and drug-specific counseling.

Prescription drug rebates

CVS Caremark administers the prescription drug benefit on behalf of Wells Fargo, but because the 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.

Genetic testing for prescription drugs

With certain prescription drugs, genetic testing can assist with determining the optimal dose for an individual. If you take one of these prescription drugs, you and your physician may be contacted to offer this testing. Participation in the testing is voluntary and any changes to your dosing or medication would be made by your doctor.

Page intentionally left blank

Chapter 4

Mental health and substance abuse benefits

If you enroll in the Anthem BCBS PPO Plan, you and your covered dependents have coverage for in- and out-of-network mental health and substance abuse services described in this chapter.

As always, it is between you and your provider to determine the treatments and procedures that best meet your needs. The terms of this chapter control what, if any, benefits are available under the Plan for the mental health or substance abuse services you receive. The fact that a provider has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular sickness or mental illness, does not mean that it is a covered mental health or substance abuse service. The definition of a covered health service under the Plan relates only to what is covered and may differ from what your provider deems to be a necessary health service.

For mental health or substance abuse treatment to be a covered health service, Anthem BCBS Behavioral Health must determine that the treatment meets the Anthem BCBS Behavioral Health coverage criteria guidelines.

Anthem BCBS Behavioral Health

Anthem BCBS Behavioral Health (ABH) is the claims administrator for mental health and substance abuse benefits described in this chapter under this Anthem BCBS PPO Plan, and provides confidential referrals for managed mental health and substance abuse care. The ABH network includes psychiatrists, psychologists, and master's level licensed therapists. Anthem Behavioral Health is staffed 24 hours a day, 365 days a year. For more information, see the "[Contacts](#)" section on page 1. To receive benefits through ABH, you must follow the process described in this chapter.

Your benefits and costs at a glance

The information in the chart below is subject to the limits and exclusions noted in this chapter. To identify providers who participate in the network, access the Provider Directory Service through *Teamworks* or at geoaccess.com/directoriestonline/wf. If online access is not available, you may request a personalized directory by phone. (See the “[Contacts](#)” section on page 1.)

Plan features	You pay in network	You pay out of network
Annual deductible*	Individual: \$300 Family: \$600	Individual: \$400 Family: \$800
Annual out-of-pocket maximum*	Individual: \$2,000 Family: \$4,000	Individual: \$4,000 Family: \$8,000
Mental health lifetime maximum	None	None
Substance abuse lifetime maximum	None	None
Mental health		
Outpatient	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Emergency	20% after deductible	20% after deductible
Prescriptions	Processed through your CVS Caremark prescription drug coverage	
Substance abuse		
Outpatient	20% after deductible	40% after deductible
Structured outpatient	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Emergency	20% after deductible	20% after deductible
Prescriptions	Processed through your CVS Caremark prescription drug coverage	

For preauthorization, contact Anthem BCBS Behavioral Health at 1-866-621-0554.

* Expenses paid by a participant toward covered medical services described in “[Chapter 2: Anthem Blue Cross Blue Shield PPO Plan](#)” starting on page 5 and covered mental health and substance abuse services described in “[Chapter 4: Mental health and substance abuse benefits](#)” starting on page 55 are applied toward the Plan’s annual deductible and annual out-of-pocket maximums. Expenses paid by a participant toward covered prescription drugs described in “[Chapter 3: Prescription drug benefit](#)” starting on page 45 are not applied toward the Plan’s annual deductible and annual out-of-pocket maximums.

Mental health and substance abuse benefits

You can discuss your mental health or substance abuse needs in confidence or seek outpatient treatment referrals by calling either Employee Assistance Consulting (EAC) or Anthem BCBS Behavioral Health at 1-866-621-0554. When you call EAC or Anthem BCBS Behavioral Health and it's not an emergency, they will give you the name, address, and telephone number of one or more network providers in your area so you can make an initial appointment.

All mental health and substance abuse benefits described in this chapter are administered by Anthem BCBS Behavioral Health.

For mental health or substance abuse treatment to be a covered health service, Anthem BCBS Behavioral Health must determine that the treatment meets the Anthem BCBS Behavioral Health coverage criteria guidelines.

Pre-service authorization required

The services listed below also require pre-service authorization in order to receive benefits. For preauthorization, contact Anthem Blue Cross Blue Shield at 1-866-418-7749 or by fax at 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

Any authorization is limited to a specific number of services for a specific period of time. If additional services are needed, you will need to obtain a new authorization before receiving those services. If you do not obtain the required authorization, you'll be responsible for all charges you incur. Refer to "[Pre-service claim](#)" in "Appendix A: Claims and Appeals" in your *Benefits Book* for more information.

- Inpatient treatment
- Out-of-network substance abuse care
- Residential treatment centers (RTC)
- Partial hospitalization
- Intensive outpatient treatment
- Structured outpatient treatment
- Autism treatment
- Psychological and neuropsychological testing

Emergency care

Please refer to the "[Emergency care](#)" section on page 16 for information.

Continuing review for hospitalization

If you are hospitalized, Anthem BCBS Behavioral Health will continue to review the medical necessity of your stay and treatment. If you receive services from an out-of-network therapist or facility, you have the option to move to a network therapist and facility where you will be covered at network benefits. If you choose not to transfer, you will receive the out-of-network benefit if available, or no coverage.

Residential treatment for children and adolescents

Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for individuals who do not require acute inpatient care but who do need 24-hour medical supervision.

To be covered, the center must include an adequate educational program, as determined by Anthem BCBS Behavioral Health at its discretion, for school-aged children and adolescents. You pay 20% after the deductible in network; you pay 40% after the deductible out of network. Preauthorization is required.

Admission to a residential treatment center is not intended for use solely as a long-term solution or to maintain the stabilization acquired during treatment in a residential facility or program.

Psychological and neuropsychological testing

Psychological and neuropsychological testing is covered, with Anthem BCBS Behavioral Health preauthorization, when conducted for the purpose of diagnosing a DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) mental disorder or in connection with treatment of such a mental disorder. You pay 20% after the deductible in network; you pay 40% after the deductible out of network. Testing is not covered to diagnose or rule out:

- Attention Deficit Disorder (ADD)
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Learning disorder or disability

Autism coverage

With Anthem BCBS Behavioral Health preauthorization, the autism benefit provides coverage for Intensive Behavioral Therapies (IBT) for team members and dependents with autism and autism spectrum disorders.

Each case will be reviewed, diagnosis validated, and treatment plan evaluated for appropriateness. Anthem BCBS Behavioral Health level of care standards shall be applied. You pay 20% after the deductible in network; you pay 40% after the deductible out of network.

The Plan covers IBTs, including applied behavioral analysis (ABA) and Repetitive Behavioral Intervention (RBI) that has been preauthorized by Anthem BCBS Behavioral Health. Coverage is as follows:

- **In network:** Clinicians must be licensed or be a board certified behavior analyst. The Plan covers 80% of covered charges and the member pays 20% after the deductible. There is no age limit and there is no day limit or dollar amount limit; however, benefits are based on medical necessity.
- **Out of network:** Clinicians must be licensed or be a board certified behavior analyst. The Plan covers 80% of covered charges and the member pays 20% after the deductible. There is no age limit and there is no day limit or dollar amount limit; however, benefits are based on medical necessity.

What is not covered

The Plan will not pay benefits for any of the services, treatments, items, or supplies described in this section, even if recommended or prescribed by a physician or therapist or if it is the only available treatment for your condition. These exclusions supersede any service listed as being covered.

In addition to any other exclusions and limitations specified in this chapter, the following are not covered as mental health or substance abuse benefits under the Plan. Some services may be eligible for some level of coverage under the Plan. Please see "[Chapter 2: Anthem Blue Cross Blue Shield PPO Plan](#)" starting on page 5 and "[Chapter 3: Prescription drug benefit](#)" starting on page 45 for more information about services and prescription drugs that may be covered by the Plan.

Charges for the following are not covered:

- Any other services, treatments, items, or supplies, other than IBT as defined by the Plan, even if recommended or prescribed by a physician, or if it is the only available treatment for autistic conditions.
- Tuition to publicly funded school-based programs for Pervasive Developmental Disorder (PDD) or any services provided by noneligible providers.
- Chelation therapy.
- Respite care.
- Vocational rehab.

- Educational services.
- Dolphin therapy.
- Recreational therapy.
- Academic education during residential treatment.
- Aversion therapy.
- Care that does not meet the Anthem BCBS Behavioral Health coverage criteria guidelines.
- Care that has not been preauthorized by Anthem BCBS Behavioral Health when required.
- Court-ordered psychiatric or substance abuse evaluation, treatment, or psychological testing, unless Anthem BCBS Behavioral Health determines that such services are medically necessary for the treatment of a DSM-IV mental disorder.
- Custodial care, regardless of the setting in which such services are provided. Custodial care is defined as services that do not require special skills or training, and that either:
 - Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring, and ambulating)
 - Do not require continued administration by trained medical personnel in order to be delivered safely and effectively
- Services for or related to educational testing or learning disabilities.
- Experimental or investigational therapies as determined by Anthem BCBS Behavioral Health. Generally, health care supplies, treatments, procedures, drug therapies, or devices that are determined to be any of the following:
 - Not generally accepted by informed health care professionals in the U.S. as effective in treating the condition, illness, or diagnosis for which their use is proposed
 - Not proven by scientific evidence to be effective in treating the condition, illness, or diagnosis for which their use is proposed
 - Undergoing scientific study to determine safety and efficacy
- Non-abstinence-based or nutritionally based substance abuse treatment.
- Charges for missed appointments, room or facility reservations, completion of claim forms, or record processing.

- Services performed by a provider who is a family member by birth or marriage, including a spouse, brother, sister, parent, or child, including any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence.
- Claims filed more than 12 months from the date of service.
- Services received after the date your coverage under the Plan ends, including services for conditions arising or under treatment before your coverage ends.
- Interest or late fees charged due to untimely payment for services.
- Private duty nursing (see the “[Extended skilled nursing care](#)” section on page 18 for more information).
- Psychiatric or psychological examinations, testing, or treatment that Anthem BCBS Behavioral Health determines is not medically necessary, but which nevertheless may be required for purposes of obtaining or maintaining employment or insurance, or pursuant to judicial or administrative proceedings.
- Psychological or neuropsychological testing that has not been preauthorized by Anthem BCBS Behavioral Health.
- State hospital treatment, except when determined by Anthem BCBS Behavioral Health to be medically necessary.
- Therapies that do not meet national standards for mental health professional practice: for example, primal therapy, bioenergetic therapy, crystal healing therapy, rolfing, megavitamin therapy, or vision perception training.
- Treatment for personal or professional growth, development, or training, or professional certification.
- Treatment for stammering or stuttering, including that to maintain employment or insurance.
- Treatment not provided by an independently licensed psychiatrist, psychologist, or master-level mental health provider.
- Treatment of chronic pain, except when rendered in connection with treatment of a DSM-IV mental disorder.
- Charges above reasonable and customary amounts as calculated by Anthem BCBS Behavioral Health using a percentage of the national Medicare fee schedule.
- Services that do not meet the criteria established in, or are excluded under, the Anthem BCBS Behavioral Health medical coverage policy guidelines.

Claims and appeals

All claims must be filed within 12 months from the date of service.

If you use a network provider, the provider will file the claim for you, and Anthem BCBS Behavioral Health will pay the provider directly.

If you use an out-of-network provider, call Anthem BCBS Behavioral Health Customer Service at 1-866-418-7749 to obtain a claim form and the correct address for filing an out-of-network claim.

If the provider files a claim on your behalf, you are still responsible for ensuring it is filed properly and within the required time frame. More information on filing claims can be found in “[Appendix A: Claims and Appeals](#)” in your *Benefits Book*.

Mental health and substance abuse claim questions, denied coverage, and appeals

If you have questions or concerns about a claim already filed with Anthem BCBS Behavioral Health, you may contact member services before filing an appeal with Anthem BCBS Behavioral Health. For more information, see the “[Contacts](#)” section on page 1.

You may also file an appeal with Anthem BCBS Behavioral Health without first contacting the Anthem BCBS Behavioral Health member services department. An 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. Once you exhaust the internal appeals procedures, you are entitled to an external review of your claim.

Complete information on appeals is provided in the *Benefits Book*, “[Appendix A: Claims and Appeals](#).”

