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

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Introduction to your medical coverage

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

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

If you have questions, call Anthem. The number is on your medical ID card and listed on the next page.

This option is self-funded by Verizon Communications Inc. and administered by Anthem, the outside administrative organization. The benefits described in this SOC are effective as of January 1, 2023.

Accessing your benefits information

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

- This EPO SOC
- The Medical SPD

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

For free printed copies of your SPD or SOC, including information regarding what legal Plan(s) and Medical SPD applies to you and links to this EPO option, contact the Verizon Benefits Center at 855.4vz.bens (855.489.2367).

Participating providers

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

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

See the “Medical plan contacts” information that follows.

Medical plan contacts

Option	Contact	Reason to access
Exclusive Provider Organization (EPO) option		
For medical care/ Mental Health and Substance Abuse	Anthem BCBS anthem.com (User ID and password required) **Member Services** 800.875.8139 **Mailing address:** Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	• Request coverage. information and order an ID card • Locate a participating provider • Request a provider listing, free of charge • Submit claims, if necessary • Check the status of a claim • Contact the Total Health Total You program through Member Services to: - Avoid denials if you need to provide notification or certification regarding emergency care, surgery, hospitalization or certain other procedures - Self-refer to the Total Health Total You program - Notify Anthem BCBS that a covered individual is pregnant • Speak to a NurseLine registered nurse
For prescription program	Express Scripts express-scripts.com/verizon **Member Services** 877.877.1878 **Mailing address** (if you use a non-participating retail pharmacy): Express Scripts P.O. Box 14711 Lexington, KY 40512 **Mailing address** (if you use home delivery): Express Scripts P.O. Box 747000 Cincinnati, OH 45274-7000	• Locate a participating pharmacy • Talk to a pharmacist • Refill or renew and track a prescription • Learn about potential savings on your prescriptions • Check on the status of pending orders • Request a home delivery form • Price a medication • Pay your balance • Print a temporary ID card

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

How the EPO option works

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

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

Using the EPO network

An EPO is a network of health care providers who agree to charge a Network Negotiated Fee (NNF) for certain services. The NNF is the maximum amount a network provider can charge for these services. See the “Accessing your benefits information” section to get a list of providers.

When you use an EPO provider, you must show your ID card to receive the Network Negotiated Fee charge.

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

Covered services

The EPO option pays benefits for Medically Necessary services and supplies, when provided or ordered by a hospital, Doctor or Physician to diagnose or treat an Illness or Injury.

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

- Be recognized throughout the Doctor or Physician's profession as safe, appropriate, effective and essential
- Be used appropriately in a manner and setting consistent with generally accepted U.S. medical standards
- Be the most efficient and economical service or supply that safely can be provided
- Not be Educational or Developmental or Experimental or Investigational in nature (except for coverage required by the ACA for participation in approved clinical trials)
- Not be solely for the convenience of the patient, the family or the provider
- Not be primarily custodial

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

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

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

- For the medical care of a diagnosed Illness, including a congenital defect or birth abnormality, or Injury and meets all of the medical necessity tests outlined earlier
- Provided immediately after the child's birth and is one of the following:
  - Hospital room and board
  - Other hospital supplies and nonprofessional services furnished to newborns

Note covered services will be paid for only the first 31 days if the newborn is not added to the plan.

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

Inpatient hospital admission Copay

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

Pre-certification

To receive benefits, you, a family member or your Physician must contact your Total Health Total You Nurse to pre-certify the following:

- Bariatric procedures
- Elective admissions
- Emergency admissions (no later than two days after the admission)
- OB-related admissions (complications, excludes childbirth)
- Newborn hospital stays beyond the stay of the mother
- Inpatient hospitalization
- Rehabilitation admissions
- Confinement in a skilled nursing facility
- Home health care
- Hospice care
- Private duty nursing
- Certain outpatient procedures, services and tests, as determined by Anthem
- All inpatient Mental Health and Substance Abuse treatment
- Outpatient psychological testing, neuropsychological testing, amytal interview and hypnosis
- Elective, rehabilitation and long-term acute care facility admissions
- All organ and bone marrow/stem cell transplants
- Nonemergency ambulance or ambulette transport
- Durable medical equipment (DME)/prosthetics/orthotics over $5,000
- Acute inpatient admissions
- Residential Care
- Partial Hospitalization
- Home infusion therapy
- Newborn stays beyond mother
- Donor Leukocyte Infusion
- Out-of-Network Radiation Therapy, Chemotherapy and Hemodialysis

Your Total Health Total You Nurse will notify you and your Physician of Anthem's decision. If you or your Physician disagree with Anthem's decision, you can appeal the decision. You must certify

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

Outpatient procedures requiring pre-certification

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

- Plastic/reconstructive surgeries
- Bariatric procedures
- Bone marrow and stem cell transplants
- Private duty nursing (home)
- Home infusion therapy
- Hospice care
- UPPP surgery (Uvulopalatopharyngoplasty – correction for sleep apnea)

Pre-certification requirements

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

Reimbursement rules with pre-certification

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

Reimbursement rules without pre-certification

If you fail to receive proper pre-certification for a service that requires pre-certification, your claim(s) will be suspended to request medical records. If the medical records are not received within 21 days, your claim will be denied and your care will not be covered by the Medical Plan. However, once the medical record information is received, your claim can be re-opened and only Medically Necessary services will be paid.

Concurrent review

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

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

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

Get Well, Stay Well, Be Well – your care management resources

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

Total Health Total You program:

- Chronic Condition Management
- MyHealth Notes (member communication)
- 24/7 Behavioral Health Support
- Building Healthy Families (maternity support)
- 24/7 Nurseline
- Inclusive Care
- Digital tools and resources

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

Total Health Total You program

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

A Total Health Total You program nurse may provide the following services:

- Inpatient care advocacy – If you are hospitalized, a Total Health Total You program nurse works with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Care management – If you have a chronic or complex condition, this program addresses such health care needs as access to medical specialists, medication information and coordination of equipment and supplies.
- Cancer support – Anthem's Total Health Total You program is available to you to provide oncology support, education and care coordination. You will have access to registered nurses and the support of social workers, pharmacists, dietitians, behavioral health specialists and exercise physiologists.

The Total Health Total You program can also help maximize your health status, improve health outcomes and control health care expenses 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)
- Low back pain – focuses on disorders of the lumbar region
- Musculoskeletal – addresses arthritis, osteoporosis and hip/knee replacements

- Vascular at-risk – targets hypertension, hyperlipidemia and metabolic syndrome as precursors of vascular diseases

You will receive:

- 24/7 phone access to a nurse coach who can answer your questions and give you up-to-date information about your condition
- A health review and follow-up calls if you need them
- Tips on prevention and lifestyle choices to help you improve your quality of life

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

Blues Distinction Center

You or your covered dependents who need a high-risk procedure may elect to use one of the hospitals included in the Blue Distinction Center network established by the claims administrator. High-risk procedures include organ or bone marrow transplants and other procedures, as determined by the claims administrator. Plan benefits for the hospitalization and transplant procedure shall be determined in the same way, regardless of whether a Blue Distinction Center network facility is used for the transplant. In addition, when a transplant procedure is performed at a designated Blue Distinction Center network facility, the Plan will pay reasonable travel and accommodation expenses (up to $10,000 per transplant) for the covered person and one companion if you must travel 75 or more miles to the facility for your transplant. Your Total Health Total You Nurse can help you locate a Blues Distinction Center network facility. You can get in touch with a Total Health Total You Nurse by calling the Member Services phone number on the back of your ID card.

Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a member who has a diagnosis of ASD. Anthem provides specialized case management services for members with autism spectrum disorders and their families. The program also includes pre-determination and medical necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders.

For families touched by ASD, Anthem's Autism Spectrum Disorders Program provides support for the entire family, giving assistance wherever possible and making it easier to understand and utilize care, resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

Education:

- Educates and engages the family on available community resources, helping to create a system of care around the member
- Increases knowledge of the disorder, resources and appropriate usage of benefits

Guidance:

- Applied Behavioral Analysis management, including clinical reviews by experienced licensed clinicians. Pre-certification delivers value, ensuring that receives the right care, from the right provider, at the right intensity.

- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning and referrals
- Assure that parents and siblings have the best support to manage their own needs

Coordination:

- Enhanced member experience and coordination of care
- Assistance in exploration of medical services that may help the member, including referrals to medical case management
- Licensed behavior analysts and program managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child

MyHealth Notes (member communication)

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

Behavioral health support

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

Building Healthy Families (maternity support)

Anthem's Building Healthy Families program recognizes every individual's and/or family's unique path to parenthood and supports them through each phase of their journey.

Personalized digital support, tracking tools, and more are available for:

- Family Planning & Fertility
- Pregnancy & Postpartum
- New Parent & Newborn
- Pediatrics
- Family Health & Emotional Wellbeing

Pregnant people can connect with a registered nurse and coaches who are available 24/7 to answer pregnancy-related questions, check in with you regularly, and provide guidance related to your medical benefits for yourself and your new family member. You can also access telehealth consultations with professionals such as dietitians and lactation consultants.

Enroll in Building Healthy Families as soon as you know you are pregnant, by logging in to the Sydney app or anthem.com and clicking Building Healthy Families or call Building Healthy Families at 866.535.5321.

Visit with a lactation consultant online

With Breastfeeding Support on LiveHealth Online, you can make appointments for free video visits with a certified lactation consultant, counselor or registered dietitian at no extra cost to you.

You can receive help with:

- Breastfeeding techniques
- Milk production
- Baby hunger cues
- Nutrition while breastfeeding

Sign up at livehealthonline.com or use the free mobile app and enter your health plan information.

Once you've created an account, select Breastfeeding Support to schedule your appointment.

24/7 NurseLine

You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day at 866.534.8434, you can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team of RNs that helps members assess systems, understand medical conditions, ensure members receive the right care in the right setting and refer you to programs and tools appropriate to your condition
- Bilingual RNs, language line and hearing-impaired services
- Proactive callbacks within 24 to 48 hours for members referred to 911 emergency services, poison control and pediatric members with needs identified as either emergent or urgent
- Referrals to relevant community resources

Other tools and resources

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

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

What is covered

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

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

The remainder of this section provides more details about covered medical services. Mental Health and Substance Abuse treatment is described in the next section.

Preventive care services

In-network preventive care services shall be covered with no cost sharing (i.e., no Copayment, coinsurance, or deductible), according to the coverage, age and frequency provisions of the Affordable Care Act. Preventive care services include routine physicals, screening tests, immunizations, mammograms, colonoscopies and other items and services that are designed to detect and treat medical conditions to prevent avoidable Illness and premature death. Preventive care services also include certain services for women: well-woman visits; screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immune-deficiency virus; U.S. Food and Drug Administration (FDA) approved contraceptive methods and counseling; breastfeeding supplies; lactation counseling; and screening and counseling for interpersonal and domestic violence as defined in guidelines from the U.S. Department of Health and Human Services, Health Resources and Services Administration. Information about what in-network preventive care items and services must be provided at no cost to you under the Affordable Care Act is available at healthcare.gov/preventive-care-benefits/.

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

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

Physician services, X-rays and diagnostic laboratory tests

Option provision	EPO pays when using network providers
Physician visits, including OB/GYN – services for diagnosis and treatment of an Illness or Injury	100%, after $25 Copay
LiveHealth Online	100% after $10 Copay
Specialist visits	100%, after $30 Copay
Allergy testing	100%
Allergy treatment – serum/injections	100%
Voluntary second surgical opinion	100%, after $25 Copay for PCP/ $30 Copay for specialist
X-rays and diagnostic laboratory tests Office visit In an outpatient facility	 100%, after $25 Copay for PCP / $30 Copay for specialist 100%
Chiropractic services Up to 20 visits per calendar year	100%, after $30 Copay
Exclusions Any type of therapy, service or supply including, but not limited to, spinal manipulations by a Physician, chiropractor or other health care professional for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring	

Hospitalization, inpatient surgery and outpatient surgery

Option provision	EPO pays when using network providers
Hospitalization and inpatient surgery	
Physician charges	100%
Facility charges	100%, after $150 per admission Copay
The EPO covers semiprivate room and board for a Medically Necessary hospital confinement, subject to pre-certification and concurrent review. Hospital services and supplies include, but are not limited to: • Anesthesia and its administration • Special diets • Intravenous solutions and injections • General nursing care (excluding care by private duty nurses) • Services of radiologists and pathologists • Routine nursery care of an eligible newborn child while the mother is hospitalized for maternity care • Use of operating, delivery, recovery and treatment rooms and equipment • Sterile tray service • Recognized drugs and medicines provided by the hospital • Dressings, splints, casts and necessary supply items • Physical, speech, vocational and occupational therapy, if needed to restore a function that was lost due to Illness or Injury	
Exclusions The EPO does not cover the following inpatient hospital services and supplies: • Hospital inpatient care if the confinement is for dental treatment or services, except in the case of: - Dental treatment or services for accidental Injury to sound, natural healthy teeth occurring while the individual is a covered person under the option - Surgery for temporomandibular joint (TMJ) disorder, unless Anthem determines that the treatment is Medically Necessary - Removal of impacted teeth if hospitalization is Medically Necessary, but only if a Physician other than a dentist certifies that hospitalization is Medically Necessary - Dental treatment or service when a Physician other than a dentist certifies that hospitalization is Medically Necessary • Hospitalization that is primarily for physical therapy or speech therapy that could have been provided on an outpatient basis • Hospitalization that is primarily for X-rays, lab and other diagnostic studies • Hospital private room charges above the most prevalent semiprivate room rate of that hospital or hospitals in the area	
Human organ and tissue transplants	100%
Your provider must pre-certify an organ transplant with your Total Health Total You Nurse for you to receive benefits. Transplants performed in non-Blue Distinction Center for Transplants (BDCT) facilities are covered at 100%.	

Option provision	EPO pays when using network providers
Human organ and tissue transplants are covered, subject to the following: • If the recipient and donor both are covered persons under the EPO, benefits are provided for both parties • If the recipient is a covered person under the EPO, but the donor is not, benefits are provided for both individuals to the extent that benefits are not provided to the donor under any other plan • If the donor is a covered person under the EPO, but the recipient is not, benefits are provided to the donor for his or her expenses only. No benefits are provided to the recipient When a transplant procedure is performed, the EPO covers eligible charges for organ and tissue transplants at 100%. It also pays reasonable travel and accommodation expenses, subject to daily limits set by Anthem and not to exceed $10,000 per transplant, for you and 1 companion (2 companions if the patient is a minor) if you must travel 75 miles or more to the facility performing the transplant. A $50 per day lodging maximum applies for double occupancy. Your provider must pre-certify an organ transplant with your Total Health Total You Nurse for you to receive benefits.	
Outpatient surgery	
Physician charges In the office In a facility	 100%, after $25 Copay for PCP /$30 Copay for specialist 100%
Covered charges may include the services of an assistant surgeon when required by the surgical procedure and approved by Anthem.	
Multiple surgical procedures If your Doctor performs 2 or more necessary surgical procedures through the same incision or operative field, the primary procedure is covered at regular rates. The EPO pays 50% of the regular benefit for the secondary procedure and 25% of the regular benefit for all other procedures. If multiple procedures are performed through different incisions during the same operation, the EPO pays regular benefits for each procedure.	
Emergency Care Emergency care is covered (in or out of network) for treatment of injuries within 72 hours of an accident or treatment of a sudden, serious and life- threatening Illness, as defined by Anthem	100%, after $150 Copay in 2023 and 2024, $155 Copay in 2025 (waived if admitted)
Non-emergency use of emergency care facilities	Not covered
Urgent care Urgent care is covered (in or out of network) for treatment of conditions or services provided that are non-preventive or nonroutine and needed in order to prevent the serious deterioration of a member's health following an	100%, after $30 Copay

Option provision	EPO pays when using network providers
unforeseen Illness, Injury or condition, as defined by Anthem	
Non-urgent use of urgent care facilities	100%, after $30 Copay

Maternity care and family planning

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

Option provision	EPO pays when using network providers
Doctor's office visits for prenatal care and the Doctor's associated delivery services	100%, $25 Copay for initial visit
Facility charges	100%, after $150 Copay

- Hospital charges for the mother and newborn for up to 48 hours after normal delivery or 96 hours after a cesarean section:
  - If the Doctor determines the hospital stay for the mother and/or her newborn should be extended, you must contact your Total Health Total You Nurse to receive full benefits for the extended portion of the stay
  - The Doctor may discharge the mother or the newborn in less time than the legally required stays of 48 hours or 96 hours, but only after consulting with the mother. For more information, see your "Your maternity rights (Newborns' and Mothers' Health Protection Act) in "Your Medical Coverage" summary plan description (SPD).
- Routine charges for the care of a newborn, including:
  - Hospital charges for nursery care, including room and board, services and supplies
  - Doctor's charge for routine visits while the baby is in the hospital
  - Surgeon’s fees for circumcision
- Any non-routine services for the care of a newborn such as, services received through the Neonatal Intensive Care Unit (NICU) or stays that extend beyond the mother, may incur separate facility and Physician charges

Birthing center Includes room and board, medical services and supplies and anesthetics and their administration	100%, after $150 Copay
Nurse-midwife services	100%
Services of a nurse-midwife who is a licensed registered nurse (L.R.N.) and has completed a state-approved nurse-midwife preparation program	
Treatment for infertility	If performed in a facility, 100% If performed in a Doctor's office, 100% after $25 Copay for PCP/$30 for specialist
Coverage includes: Services to diagnose and treat infertility. Treatment for underlying medical conditions are covered as medical.	

Option provision	EPO pays when using network providers
• Artificial Insemination is covered at 100%, not subject to deductible. Subject to a $25 PCP /$30 specialist Copay if performed in the office. 6 courses maximum per Lifetime. • In-Vitro Fertilization, GIFT and ZIFT covered at 90% not subject to deductible. $75,000 per lifetime maximum (combined with Pharmacy) for infertility services. • Cryopreservation of embryos (e.g. in conjunction with IVF) is covered after 90% coinsurance subject to the $75,000 lifetime maximum. Storage is covered in full the first year and at coinsurance (deductible waived) in subsequent years. Cryopreservation of eggs/oocytes (used to delay child-bearing) is covered once per lifetime subject to coinsurance limited to the $75,000 lifetime maximum (combined with Pharmacy) for infertility services.	
Surgery for sterilization	If performed in a facility, 100% If performed in a Doctor's office, 100% after $25 Copay for PCP/$30 for specialist
Coverage includes: • An initial voluntary sterilization procedure for a male or female without a waiting period or Doctor's approval. Reversals of voluntary sterilization procedures are not covered.	

Skilled nursing care, home health care and hospice care

Option provision	EPO pays when using network providers
Skilled nursing facility Up to 120 days per calendar year	100%, after a $150 Copay
While you may not need the level of care provided in a hospital, you still may need 24-hour medical supervision. As long as you remain under a Doctor's care, the EPO covers care in a skilled nursing facility when Medically Necessary, including: • Room and board, including general nursing services, meals and special diets • Use of special treatment rooms • Prescription drugs prescribed by the Physician, but only if billed for and provided by the skilled nursing facility • Medical and surgical dressings, supplies, casts and splints • Diagnostic services • Therapy services • Physicians' medical visits and consultations, up to 1 visit per day	
A skilled nursing facility is a facility that provides Medically Necessary continuous professional nursing supervision to covered persons who are not in the acute phase of Illness but require primarily convalescent, rehabilitative and/or restorative services. The facility also may include intermediate, residential or long-term care units. Beds must be set up and staffed in a unit(s) specifically designated for this service. The facility must meet all of the following requirements: • Is licensed to provide, and provides, the following on an inpatient basis for covered persons convalescing from Illness or Injury: professional nursing care, 24 hours a day, by a registered nurse (R.N.) or by an L.P.N. directed by a full-time R.N.; and physical restoration services to help covered persons meet a goal of self-care in daily living activities. • Is supervised full time by a Physician or an R.N.	

Option provision	EPO pays when using network providers
• Keeps a complete medical record on each patient • Has a utilization review plan • Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mentally retarded persons, for Custodial Care or Educational or Developmental care, or for care of mental disorders • Charges for its service	
Exclusions • Physicians' medical visits in a skilled nursing facility in excess of 1 visit per day • Treatment of covered persons who have reached the maximum level of recovery possible for their particular condition and who no longer require definitive treatment other than routine supportive care • Treatment that is needed only to assist with the simple activities of daily living or to provide the protection of an institutional environment as a convenience to you • Custodial Care that does not require medical or nursing services • Treatment of primary mental Illness, including drug addiction, chronic brain syndrome and alcoholism without other specific medical conditions of a severity to require care. However, this exclusion does not apply to covered persons with primary Illness receiving short-term convalescent care for a secondary medical condition for whom prognosis for recovery or improvement is considered favorable for that medical condition • Treatment of covered persons suffering senile deterioration who do not have a treatable medical condition requiring attention • Maternity care and care for newborns or infants Private duty nursing is not covered except as described under "Home health care" and "Outpatient private duty nursing."	
To be eligible for benefits, call your Total Health Total You Nurse before receiving home health care services	
Home health care Up to 120 visits per calendar year Home IV therapy visits do not count towards the maximum	100%
Sometimes a hospital stay can be shortened or avoided altogether if medical services can be provided at home. The EPO covers expenses: • For home health care treatment plans ordered and supervised by your Doctor • Provided by a home health care agency including: - Part-time or intermittent nursing care by or under the supervision of an R.N. or by a qualified home health aide - Physical, occupational and speech therapy	
A home health care agency must meet Anthem's requirements, which include the following: • Is licensed in the state where it is located, if required • Operates according to state laws • Has a full-time administrator and its staff includes at least 1 Physician and 1 R.N	
Home health care benefits are calculated on a per-visit basis. 4 hours of care by a home health care aide are considered 1 visit and each visit by a nurse or therapist is considered 1 visit.	

Option provision	EPO pays when using network providers
To be eligible for benefits, call your Total Health Total You Nurse before receiving home health care services.	
Exclusions Services for Custodial Care, services of a social worker, transportation or any period that you are not under the care of a Doctor	
Outpatient private duty nursing (covered as part of home health care) Up to 120 visits per calendar year	100%
• Part-time or intermittent nursing care by or under the supervision of an R.N. or by a qualified home health aide • Charges made by a R.N. or L.P.N. or a nursing agency for private duty nursing care • Private duty nursing by a R.N. or L.P.N. means that the person's condition requires skilled nursing services and visiting nursing care is not adequate Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the private duty nursing care maximum shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	
Exclusions • That part or all of any nursing care that does not require the education, training and technical skills of a R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs and companionship activities • Any private duty nursing care given while the person is an inpatient in a hospital or other health care facility • Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair or toileting care provided solely for skilled observation except: - For no more than one 4-hour period per day, for a period of no more than 10 consecutive days following the occurrence of any of these: • Change in patient medication • Need for treatment of an emergency condition by a Physician or the onset of symptoms indicating the likely need for such treatment • Surgery • Release from inpatient confinement - Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by a R.N. or L.P.N. To be eligible for benefits, call your Total Health Total You Nurse before receiving home health care services.	
Hospice care	100%
Hospice programs provide care to meet the physical and psychological needs of terminally ill patients at home or at a facility where patients are cared for in a comfortable and supportive home-like environment. A patient is considered terminally ill if he or she has a life expectancy of less than 12 months. The purpose is to make the patient comfortable, rather than to attempt a cure. Often, hospitals set aside a floor or a wing as a hospice center. Hospice care must be provided through the EPO's hospice care program, which includes a written plan that includes an assessment of the patient's medical and social needs and a description of	

Option provision	EPO pays when using network providers
the care to be given. Before receiving hospice services, call your Total Health Total You Nurse to be sure you are eligible to receive benefits. The EPO covers the following hospice care services: • Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day • Part-time or intermittent home health aide services for up to 8 hours a day. These consist mainly of caring for the person. • Services and supplies provided by a Physician, dietician, social worker, respiratory therapist, physical therapist, speech therapist and occupational therapist • Counseling services for the patient and his or her immediate family during the Illness • Pastoral counseling • Medical supplies and prescribed drugs and medicines • Semiprivate room and board and general nursing care on an inpatient basis • An unlimited number of telephone counseling sessions for the patient and surviving covered family members while the patient is receiving hospice care, as well as 5 visits of bereavement counseling for your immediate family	
Exclusions • Funeral expenses • Financial or legal counseling. This includes estate planning and the drafting of a will. • Homemaker or caretaker services and respite care. These are services that are not solely related to the care of the person. Such services include sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house	

Other services

Option provision	EPO pays when using network providers
Medical services and supplies	100%
The EPO pays for the following: • Medical and surgical supplies including bandages, dressings, orthopedic braces and crutches ordered by a Doctor or Physician. Contact your Total Health Total You Nurse if a durable medical equipment purchase will exceed $5,000. • Blood and blood derivatives that are not donated or otherwise replaced • Oxygen and its administration, including the rental of required equipment	
Physical therapy and occupational therapy Up to a combined maximum of 60 visits per calendar year for physical, occupational and speech therapy Covered unlimited for the diagnosis of Autism Spectrum Disorder	100%, after $30 Copay
Coverage is provided only for rehabilitation services that are expected to result in measurable, documented improvement in the patient's condition. The EPO covers up to a combined maximum of 60 visits during a calendar year for physical, occupational and speech therapy to a licensed physical or occupational therapist. Covered	

Option provision	EPO pays when using network providers
unlimited for the diagnosis of Autism Spectrum Disorder.	
Speech therapy Up to a combined maximum of 60 visits per calendar year for physical, occupational and speech therapy Covered unlimited for the diagnosis of Autism Spectrum Disorder	100%, after $30 Copay
Speech therapy benefits are available only for rehabilitation services that are expected to result in measurable, documented, physical improvement in the condition. The options cover up to a combined maximum of 60 visits during a calendar year for physical, occupational and speech therapy, provided by a licensed speech therapist. Covered unlimited for the diagnosis of Autism Spectrum Disorder.	
Rehabilitation therapy Coverage is provided for inpatient or outpatient rehabilitation therapy that is necessary to improve the ability to function independently. Inpatient rehabilitation therapy includes room and board, care and treatment. Outpatient therapy includes the services of a hospital or comprehensive outpatient rehabilitative facility.	
Exclusions Any type of therapy, service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	
Emergency ambulance service	100%
Coverage is provided for professional ground ambulance to and from a hospital or other medical facility for emergency services. Coverage is also provided for an air ambulance when Medically Necessary	
Durable medical equipment	100%
Coverage is provided for the rental or purchase of durable medical equipment. If the cost of the purchase or rental is more than $5,000, you must contact your Total Health Total You Nurse for a determination as to what benefits are available. The claims administrator determines whether an item is eligible for rental or purchase, regardless of cost. Deluxe wheelchairs are covered up to the allowance of the base model.	
Acupuncture services Up to 20 visits per calendar year	100%, after $30 Copay
Anthem customarily covers acupuncture services in connection with surgery and in other Medically Necessary situations. The option covers up to a maximum of 20 visits during a calendar year for acupuncture treatment of pain and nausea by an M.D., D.O., D.C. or acupuncturist licensed by the state or certified by the National Commission of Acupuncturists/OMD. Additional services are covered if approved by the claims administrator.	

Option provision	EPO pays when using network providers
Foot Care	Covered based on place of service and the procedures being billed
Coverage is available for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities. Shoe inserts, orthotics will be covered at 100%, no deductible if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).	
Radiation therapy	100%, after $20 Copay for PCP/$30 Copay for specialist per visit
Chemotherapy	In a facility, 100% In a Doctor's office, 100%
Reconstructive surgery	In an outpatient facility, 100% In a Doctor's office, 100% after $25 Copay for PCP/$30 Copay for specialist per visit In an inpatient facility, 100% after $150 Copay
Coverage is provided: • When considered Medically Necessary. Procedures are considered Medically Necessary if there is a significant functional impairment and the procedure can be reasonably expected to improve the physical functional impairment. • For breast reconstruction (including repigmentation) to restore the physical appearance of the breast following a necessary mastectomy. For more information, see "Your rights following a mastectomy (Women's Health and Cancer Rights Act of 1998)" in "Your Medical Coverage" SPD. • Coverage for care related to Gender Dysphoria or gender transition services that are Medically Necessary are covered. Contact Anthem or the prescription drug administrator, such as Express Scripts, for more details on what gender transition services and benefits are available. • For additional reconstruction purposes, when intended to address a significant variation from normal related to accidental Injury, disease, trauma, treatment of a disease or congenital defect Contact your Total Health Total You Nurse before undergoing a reconstructive procedure to verify that the procedure is covered and not considered cosmetic in nature.	
Artificial limbs or eyes	100%
Artificial limbs or eyes and other appliances are covered for the replacement of a body organ or part. The EPO covers the first appliance only, unless a replacement is necessary because of growth and physical change. If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.	
Oral surgery Office visit	100%, after $25 Copay for PCP/ $30 Copay for specialist per visit

Option provision	EPO pays when using network providers
In a facility	100%
Coverage is provided for: • Oral surgery performed for the treatment of non-dental diseases, injuries and defects of the mouth, the jaws and associated structures • The excision of bone or tissue from other than the oral cavity as a donor site for purposes of grafting, in connection with dental surgery covered under the Verizon dental plan, as long as the grafting is necessary due to an accidental Injury or Illness. See "Your Dental Coverage" SPD for more information. • Surgical treatments of TMJ disorder, as long as they are Medically Necessary • Anesthesia in connection with covered oral surgery, as long as it is Medically Necessary Expenses for oral surgery should be submitted to the Verizon dental plan first. If the Verizon dental plan does not cover all the charges, submit your claim to the Verizon medical plan for review.	
Treatment of TMJ dysfunction Office visit	100%, $25 Copay for PCP/ $30 Copay for specialist per visit
In a facility	100%
Coverage includes exams, X-rays, injections, anesthetics, physical therapy, oral surgery and supplies	
Exclusions Tooth reconstruction or any treatment that is not medical in nature	
Hearing aids and supplies	100%
Covered for dependents up to age 18 with hearing loss due to birth defect, Illness, Injury or accident. Not covered for progressive hearing loss. Includes hearing exams and hearing aid accessories.	
Vision services (non-routine)	100%, $25 Copay for PCP/ $30 Copay for specialist per visit
Coverage is provided for services for the treatment of disease or Injury to the eye. Routine vision services other than routine screening included as part of a routine physical are not covered. • Corrective lenses, contacts and frames are only covered, once per lifetime following cataract surgery • One pair of intraocular lenses is covered once per lifetime following cataract surgery • Deluxe intraocular lenses are payable up to the allowance of the base model	
Nutritional counseling	100%, after $25 Copay for PCP/ $30 Copay for specialist per visit
Nutritional counseling is covered only for diabetic education. Nutritional counseling covered for members with an eating disorder diagnosis with no visit limits.	
Foreign care All services received while out of the country, as long as they are covered services under the plan, will be covered at the in-network level of benefits. The claim is converted to local currency at the exchange rate in effect at the time the claim is processed.	

What is not covered

Here are examples of expenses not covered.

- Care, treatment, services or supplies that are not Medically Necessary, as determined by Anthem
- Care, treatment, services or supplies that are not prescribed, recommended and approved by your attending Physician or dentist
- Use of an ambulatory surgical facility for dental procedures, unless such use is Medically Necessary
- Anesthesia when:
  - A separate charge is made and anesthesia is administered by a surgeon or assistant surgeon in connection with surgery
  - It is administered by the same Physician who administers electroshock therapy
  - It is rendered in connection with a service that is not a covered service
- Regular dental care and treatment, such as:
  - Preventive care, including fillings
  - Removal or replacement of teeth
  - Fluoride treatment
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Appliances to correct temporomandibular joint (TMJ) disorder
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy, augmentation and vestibuloplasty
  - Treatment of periodontal disease
  - Prosthetic restoration of dental implants
- The replacement of durable medical equipment due to loss or negligence, or because a newer or more efficient model is available
- In-hospital visits for customary preoperative and postoperative care
- In-hospital visits by a Physician in excess of one visit per day per specialty
- A preoperative work-up by the surgeon who performs or assists with major surgery, except for charges for a separate consultation when rendered in connection with minor or diagnostic surgery
- Staff consultations required by hospital rules
- Replacement of a prosthesis, except as specifically provided, including replacement of an outdated prosthesis that the EPO administrator determines still is functional or able to be repaired
- Items that are considered capital improvements to the home, such as electrical wiring and plumbing, regardless of whether such improvements constitute medical care under the Internal Revenue Code
- Surgical treatment for weight reduction or control, unless there is a diagnosis of Morbid Obesity, and it is approved by Anthem. See the “Medical plan contacts” section for contact information.
- Plastic surgery, reconstructive surgery, cosmetic surgery or other services or supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, however, care related to Gender Dysphoria or gender transition services that are Medically Necessary are covered. Cosmetic surgery will be covered only if it results in improved bodily function or as described under “Other services.” However, complications resulting from elective procedures are covered.

- Care in an institution that is primarily for convalescent or domiciliary care, or Custodial Care, such as a place of rest, a home for the aged, a nursing home, a half-way house or a hotel
- Diagnostic X-rays and laboratory and machine tests not consistent with the diagnosis, symptoms or Illness
- Athletic club dues or exercise equipment for the home
- Reversal of a sterilization procedure
- Services or supplies that are not necessary, as determined by Anthem, for the diagnosis, care or treatment of the disease or Injury involved. This applies even if such services or supplies are prescribed, recommended or approved by the person's attending Physician or dentist.
- Services or supplies for sexual dysfunction or inadequacies that do not have a physiological or organic basis
- Services or supplies that Anthem determines are Educational or Developmental services or supplies, or for education or job training
- Except in special circumstances as determined by Anthem, inpatient private duty nursing services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.)
- Services recommended by a nonprofessional or services performed at your request
- Chiropractic care, developmental therapy, physical therapy, speech therapy and other therapy services for maintenance after the optimum level of improvement has been reached, as determined by Anthem
- Eye surgery to correct refractive errors
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy. Court-ordered services, or those required by court order as a condition of parole or probation.

Charges by certain providers

- Charges of a Physician or other professional provider on "stand-by" in the event complications might occur
- Surgical or routine maternity care visits while hospitalized, to the extent those visits are considered part of the surgeon's or obstetrician's fee, as determined by Anthem
- The administration of anesthesia by the surgeon, assistant surgeon or Physician who also renders diagnostic tests, performs surgery or provides any other services for the same procedure
- Professional services provided to you by a family member or by a person residing in your home

Routine or convenience items

- Routine foot care (such as removal of corns and calluses, orthopedic shoes, insoles and arch supports) except as described in the "What is covered" section.
- Routine eye examinations, eyeglasses, contact lenses and eye refractions for the fitting of glasses, except as specifically provided under the plan
- Routine hearing examinations, except as specifically provided under the plan
- Routine dental examinations
- Vitamins, food and food supplements used as dietary supplements, except as provided under the prescription program or except when determined to be Medically Necessary
- Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
- Personal comfort or beautification items while hospitalized, such as TV rentals, barber services and guest meals
- Inoculations, vaccinations, immunization shots, preventive gammaglobin shots, etc., except as specifically provided under the plan

- Diversional or recreational therapy
- Convenience items, even when prescribed by the Physician or provided by a hospital, if not Medically Necessary for treatment of your medical condition
- Miscellaneous equipment, including:
  - Air conditioners
  - Bed rails, tables, trays or boards (except if an integral part of the hospital bed)
  - Bicycles
  - Children’s strollers
  - Dietetic or health foods
  - Electric fans
  - Enuresis units
  - Escalator or elevator for your home
  - Food liquidators
  - Handrails
  - Heating pads
  - Heating units for swimming pools
  - Humidifiers
  - Hypo-allergenic cosmetics or toiletries
  - Ice bags
  - Mattresses, except when purchased with a hospital bed
  - Niagra vibrators
  - Overbed tables
  - Puritron air fresheners
  - Ramps
  - Scales (weight)
  - Telephones
  - Thermometers
  - Vaporizers
  - Walking canes with seat
  - Wig styling

Other exclusions

- Charges that are more than the Network Negotiated Fee, Maximum Allowed Amount or in excess of any applicable annual maximum, as determined by Anthem
- Services or supplies for which there is no legal obligation to pay, unless otherwise required by federal law
- Services for which the Physician or other provider does not customarily bill his or her patient
- Charges that are made only because there is health coverage
- Services or supplies provided because of Injury or Illness due to an act of declared war in the United States
- Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
- Hospitalization that begins before the effective date of your coverage or after your coverage has ended, except as specifically provided
- Hospital room, board and ancillary services or supplies, when hospital confinement is or becomes primarily rehabilitative, except as specifically provided, unless your diagnosis and condition is such that rehabilitation cannot be provided on an outpatient basis

- Use of a facility that is part of a hospital or an approved skilled nursing facility is covered when rehabilitation is Medically Necessary, as determined by Anthem, due to an accidental Injury, spinal Injury or an Illness such as a stroke
- Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy.
- Any service or supply rendered before the effective date of coverage or after coverage has ended
- Charges for maintaining an environment suitable for preventing the worsening of a medical condition
- Admitting fees, deposits, telephone consultations, missed appointments and completion of claim forms
- Services or supplies covered under any federal or state “no-fault” motor vehicle insurance provision that relates to medical treatment or other mandated insurance, regardless of whether you properly assert your rights under the motor vehicle insurance contract
- Services or supplies for which you recover the cost by legal action, insurance proceeds or settlement from a third party whose negligent or wrongful actions have caused or are alleged to have caused your Illness or Injury, or from the insurer of the third party
- Services or supplies that are furnished, paid for or otherwise provided by a local, state or federal governmental agency, except as otherwise required by law
- Services or supplies that are furnished, paid for or otherwise provided or required for treatment of a military service-connected disability or because of the present service of any person in the armed forces of a government
- Services or supplies provided for any condition covered by Workers’ Compensation laws, or for any other occupational condition, ailment, Injury or Illness occurring on the job, if:
  - Your employer provides reimbursement for these charges
  - Your employer makes a settlement for these charges
  - You fail to assert your rights in attaining reimbursement from the employer

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

Mental Health and Substance Abuse Treatment coverage

You have access to Medically Necessary treatment for Mental Health Disorders and Substance Abuse. Coverage is provided through Anthem's Behavioral Health program. Your expenses are not covered by the EPO option if you use providers who do not participate in the Anthem BlueCard PPO network.

Medically Necessary

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

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

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

How Anthem's Behavioral Health Program works

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

What is covered under Mental Health and Substance Abuse treatment

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

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

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

- Receive guidance on the best use of your benefit, including referrals to qualified in-network providers
- Receive information about other programs, services and tools that can support your mental health and wellness

- Address any questions that you may have regarding your Mental Health and Substance Abuse benefit

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

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

Covered Mental Health and Substance Abuse treatment

Covered Mental Health and Substance Abuse treatment	EPO option pays using network providers
Inpatient hospital treatment	100%, after $150 hospital admission Copay
Outpatient treatment	100%, after $ $25 Copay
Partial hospitalization	In a facilty,100%
To be covered, treatment programs must: • Provide evaluation, diagnostic and counseling services • Be licensed and accredited, if required • Comply with any local laws governing treatment programs • Be Medically Necessary	

How benefits are paid

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

What is not covered

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

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

- Gambling programs based solely on the 12-step model
- Primal therapy
- Private duty nursing
- Private rooms (except when required for infection control)
- Transcendental meditation
- Treatment of sexual addiction, co-dependency or any other behavior that does not have a DSM-V diagnosis
- Mental and psychoneurotic disorders not listed in the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-10)
- Court-mandated or legally mandated treatment that is not considered Clinically Necessary, as determined by Anthem, or that would not otherwise be covered
- Services or supplies that are determined by Anthem not to be Clinically Necessary, including any confinement or treatment given in connection with a service or supply that is not Clinically Necessary
- Services or supplies you receive before you became covered under the EP.
- Treatment for any of the following diagnoses: mental retardation (except the initial diagnosis), pervasive developmental disorders, chronic organic brain syndrome or learning disabilities
- Failure to submit completed claim forms
- Missed appointments
- Custodial Care
- Ecological or environmental medicine, diagnosis or treatment
- Education, training and room and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy.
- Excluded forms of therapy include, but are not limited to; Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
- Herbal medicine or holistic or homeopathic care, including drugs
- Services, supplies, medical care or treatment given by one of the following members of your immediate family:
  - Your spouse, child, brother, sister, parent or grandparent
  - A child, brother, sister, parent or grandparent of your spouse or domestic partner
- Services, supplies, treatments or drugs that have not been scientifically proven to be a treatment option or have not been certified by the FDA because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, services or supplies.
- Services or supplies for which you are not legally required to pay
- Membership costs for health clubs, weight loss clinics and similar programs
- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualify as Mental Health or Substance Abuse treatment Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes and related expenses for reports, including report presentation and preparation
- Services given by a pastoral counselor
- Personal convenience or comfort items including, but not limited to, televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs
- Private duty nursing services while confined in a facility
- Sensitivity training, educational training therapy or treatment for an education requirement
- Stand-by services required by a Physician
- Telephone consultations

- Tobacco dependency
- Services or supplies received because of war, declared or undeclared or international armed conflict
- Mental health treatment for weight reduction or control (unless there is a diagnosis of Morbid Obesity) or eating disorder, special foods, food supplements, liquid diets, diet plans or any related products
- Services given by volunteers or persons who do not normally charge for their services
- Care received in a residential treatment center

Prescription Drug Program for the EPO option

Your prescription coverage includes:

- A retail prescription benefit
- A mail-order benefit

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

Prescription Drug Program overview

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

Prescription Drugs	In Network	Out-of-Network
Retail Pharmacy (supply appropriate for up to 30 days of therapy)		
Annual deductible	No deductible required	$50 combined for Generic and Brand-Name Drugs
Coinsurance		
Generic Drugs	• You pay the Discounted Network Price (DNP), but no more than a $10.91 Copay per prescription[1] • Once you obtain three fills of a prescription for a maintenance medication from an In-Network Pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP. Fixed dollar maximum Copays will not apply.	After the deductible is met, you pay 100% of the cost difference between the DNP and retail cost. In addition: • You pay 30% of the DNP cost for the original prescription and each refill. • Once you obtain three fills of a prescription for a maintenance medication from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP.

[1] For 2023 and for each calendar year thereafter, the maximum Copay will increase when compared to the maximum Copay for the prior calendar year by the percent equal to the percent increase in the per prescription cost of Generic Drugs in the prescription drug program for NYNE active associates between the year that was 3 years prior and the year that was 2 years prior, up to a maximum of 4% (the "Generic Trend Percentage"). For example, and solely for avoidance of doubt, for calendar year 2023, the maximum Copay for Generic Drugs will increase by the percent equal to the percent increase in the per prescription cost of Generic Drugs in the prescription drug program for NYNE active associates between 2020 and 2021, up to a maximum of 4%. If between 2020 and 2021, the per prescription cost of Generic Drugs in the prescription drug program for NYNE active associates increases by 3%, then the Generic Trend Percentage for 2023 shall be 3% and the 2023 maximum Copay for Generic Drugs shall be an amount that is 3% greater than the 2022 maximum Copay for Generic Drugs.

Prescription Drugs	In Network	Out-of-Network
Brand-Name Drugs - Preferred	• You pay 20% of the DNP but no more than a $33.63 Copay per prescription[2]. • If you choose a Brand-Name Drug when a Generic equivalent is available, you will pay the Generic Copay/coinsurance plus 100% of the cost difference between the Brand-Name and Generic Drug. The maximum Copay will not apply.[3] • Once you obtain three fills of a prescription for a maintenance medication from an in-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP and maximum dollar Copays will not apply	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. In addition: • You pay 40% of the DNP for the original prescription and each refill. • If you choose a Brand-Name Drug when a Generic equivalent is available, you will pay the Generic Copay/coinsurance plus 100% of the cost difference between the Brand-Name and Generic Drug.[3] • Once you obtain three fills of a prescription for a maintenance medication from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP.
Brand-Name Drugs - Non-Preferred	• You pay 30% of the DNP but no more than a $56.05 Copay per prescription[4]. • If you choose a Brand-Name Drug when a	After the deductible is met, you pay 100% of the cost difference between the DNP and the retail cost. In addition:

[2] For 2023 and for each calendar year thereafter, the maximum Copay will increase when compared to the maximum Copay for the prior calendar year by the percent equal to the percent increase in the per prescription cost of all non-compound Brand-Name Drugs (preferred and non-preferred) in the prescription drug program for NYNE active associates between the year that was three years prior and the year that was two years prior, up to a maximum of 6% (the "Brand Trend Percentage"). For example, and solely for avoidance of doubt, for calendar year 2023, the maximum Copay for Brand-Name preferred drugs will increase by the percent equal to the percent increase in the per prescription cost of non-compound Brand-Name drugs (preferred and non-preferred) in the prescription drug program for NYNE active associates between 2020 and 2021 up to a maximum of 6%. If between 2020 and 2021 the per prescription cost of non-compound Brand-Name Drugs (preferred and non-preferred) in the prescription drug program for NYNE active associates increases by 15%, then the Brand Trend Percentage for 2023 shall be 6% and the 2023 maximum Copay for brand preferred drugs shall be an amount that is 6% greater than the 2022 maximum Copay for Brand preferred drugs.

[3] Does not apply for Brand-Name Drugs where there is a Generic equivalent and the claims administrator approves your Doctor's certification that you are medically unable to take the Generic version of the medication. If the claims administrator approves your request, the cost-sharing that applies to Brand-Name Drugs with no Generic available will apply.

[4] For 2023 and for each calendar year thereafter, the maximum Copay will increase when compared to the maximum Copay for the prior calendar year by the Brand Trend Percentage. For example, and solely for avoidance of doubt, for calendar year 2023, the maximum Copay for Brand-Name non-preferred drugs will increase by the percent equal to the percent increase in the per prescription cost of non-compound Brand-Name drugs (preferred and non-preferred) in the prescription drug program for NYNE active associates between 2020 and 2021, up to a maximum of 6%. If between 2020 and 2021, the per prescription cost of non-compound Brand-Name Drugs (preferred and non-preferred) in the prescription drug program for NYNE active associates increased by 20%, then the Brand Trend Percentage for 2023 shall be an amount that is 6% and the 2023 maximum Copay for Brand non-preferred drugs shall be an amount that is 6% greater than the 2022 maximum Copay for Brand non-preferred drugs.

Prescription Drugs	In Network	Out-of-Network
	Generic equivalent is available, you will pay the Generic Copay/coinsurance plus 100% of the cost difference between the Brand-Name and Generic Drug. The maximum Copay will not apply.[3] • Once you obtain three fills of a prescription for a maintenance medication (i.e. the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP and maximum dollar Copays will not apply.	• You pay 40% of the DNP for the original prescription and each refill. • If you choose a Brand-Name Drug when a Generic equivalent is available, you will pay the Generic Copay/coinsurance plus 100% of the cost difference between the Brand-Name and Generic Drug.[3] • Once you obtain three fills of a prescription for a maintenance medication from an out-of-network pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you will pay 50% of the DNP.
Mail Service Pharmacy (supply appropriate for up to 90 days of therapy)		
Generic Drugs	• You pay the DNP per prescription, but no more than a $21.82 Copay.	None
Brand-Name Drugs - Preferred	• You pay 20% of the DNP, but no more than $67.26 Copay per prescription. • If you choose a Brand-Name Drug when a Generic equivalent is available, you will pay the Generic Copay/coinsurance, plus 100% of the cost difference between the Brand-Name and Generic Drug. The maximum Copay will not apply.[3]	None
Brand-Name Drugs - Non-Preferred	• You pay the 30% of the DNP per prescription but no more than a $112.10 Copay per prescription. • If you choose a Brand-Name Drug when a Generic equivalent is	None

Prescription Drugs	In Network	Out-of-Network
	available, you will pay the Generic Copay/coinsurance, plus 100% of the cost difference between the Brand-Name and Generic Drug. The maximum Copay will not apply.[3]	

Retail prescription benefit

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

Using an In-Network Pharmacy

When you use an In-Network Pharmacy, you pay:

- For a Generic Drug, you'll pay the Discounted Network Price (DNP) for each prescription drug, but no more than a $10.91 Copay. For 2023 and each calendar year thereafter, the maximum Copay will increase up to a maximum of 4 percent each year.

- For Brand-Name preferred drugs, you'll pay 20 percent of the DNP (but no more than a $33.63 Copay) for each prescription in 2023. For 2024 and each calendar year thereafter, the maximum Copay will increase up to a maximum of 6 percent per year. If you choose a Brand-Name preferred drug when a Generic equivalent is available, you'll pay the Generic Copay/coinsurance, plus 100 percent of the cost difference between the Brand-Name and the Generic Drug; the fixed dollar maximum Copays do not apply. This additional cost will apply unless your Doctor certifies that you are medically unable to take the Generic medication and the exception is approved by Express Scripts.

- Example: You select a Brand-Name preferred drug with a DNP of $20. This particular Brand-Name Drug also has a Generic equivalent with a DNP of $10. In this example, in 2023, you would pay a $10.91 Copay plus the cost difference between the Brand-Name preferred and Generic Drug ($20 minus $10 which is equal to $10). Your total cost would be $20.

- For Brand-Name non-preferred drugs, you'll pay 30 percent of the DNP (but no more than a $56.05 Copay) for each prescription in 2023. For 2024 and each calendar year thereafter, the maximum Copay will increase up to a maximum of 6 percent per year. If you choose a Brand-Name non-preferred drug when a Generic equivalent is available, you'll pay the Generic Copay/coinsurance, plus 100 percent of the cost difference between the Brand-Name and Generic Drug; the fixed dollar maximum Copays do not apply. This additional cost will apply unless your Doctor certifies that you are medically unable to take the Generic medication and the exception is approved by Express Scripts.

- Example: You select a Brand-Name non-preferred drug with a DNP of $20. This particular Brand-Name Drug also has a Generic equivalent with a DNP of $10. In this example, in 2023, you would pay a $10.91 Copay plus the cost difference between the Brand-Name preferred and Generic Drug ($20 minus $10 which is equal to $10). Your total cost would be $20.

- Once you obtain three fills of a prescription for a maintenance medication from an In-Network Pharmacy (i.e., the initial prescription plus two refills), then you must use the mail-order pharmacy or you'll pay 50 percent of the DNP; the fixed dollar maximum Copays will not apply. This requirement applies regardless of whether you are purchasing a Generic, Brand-Name preferred or Brand-Name non-preferred drug.

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

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

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

Using an out-of-network pharmacy

When you use an out-of-network pharmacy, you pay an annual $50 per person prescription deductible, combined for Generic and Brand-Name Drugs. After the annual deductible is met, you also pay:

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

- For a Brand-Name preferred or non-preferred drug, you'll pay 40 percent of the DNP for each prescription drug. In addition, you'll pay 100 percent of the cost difference between the DNP and the retail cost. If you choose a Brand-Name Drug when a Generic equivalent is available, you'll pay the Generic Copay/coinsurance plus 100 percent of the cost difference between the Brand-Name retail cost and Generic Drug DNP. This additional cost will apply unless your Doctor certifies that you are medically unable to take the Generic medication and the exception is approved by Express Scripts.

- Example: You select a Brand-Name preferred drug with a DNP cost of $50. This Brand-Name Drug has a retail cost of $75. This particular Brand-Name Drug also has a Generic equivalent with a DNP cost of $20 and a retail cost of $35. In this example, in 2023, you would pay $6 (30% of the Generic equivalent DNP of $20) plus the cost difference between the Brand-Name retail cost and Generic Drug DNP ($75 minus $20 which is equal to $55). Your total cost would be $61 (in addition to all or any portion of the annual $50 deductible that applies).

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

Your costs could be much higher based on the retail cost of the drug. You pay the full bill at the pharmacy and file a claim for reimbursement.

Mail-order prescription benefit

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

- For a Generic Drug, you'll pay the DNP for each prescription drug, but no more than a

$21.84 Copay in 2023. For 2024 and each year thereafter, the maximum Copay will be 2 times the maximum Copay for that year for Generic Drugs purchased at In-Network Pharmacies.

- For a Brand-Name preferred drug, you'll pay 20 percent of the DNP for each prescription drug, but no more than a $67.26 Copay in 2023. For 2024 and each calendar year thereafter, the maximum Copay will be two times the maximum Copay that year for Brand-Name preferred drugs purchased at In-Network Pharmacies. If you choose a Brand-Name preferred drug when a Generic equivalent is available, you'll pay the Generic Copay/coinsurance plus 100 percent of the cost difference between the Brand-Name and Generic Drug; the fixed dollar maximum Copays do not apply. This additional cost will apply unless your Doctor certifies that you are medically unable to take the Generic medication and the exception is approved by Express Scripts.

- For a Brand-Name non-preferred drug, you'll pay 30 percent of the DNP for each prescription drug, but no more than a $112.10 Copay in 2023. For 2024 and each calendar year thereafter, the maximum Copay will be 2 times the maximum Copay for that year for Brand-Name non-preferred drugs purchased at In-Network Pharmacies. If you choose a Brand-Name Drug when a Generic equivalent is available, you'll pay the Generic Copay/coinsurance, plus 100 percent of the cost difference between the Brand-Name and Generic Drug; the fixed dollar maximum Copays do not apply. This additional cost will apply unless your Doctor certifies that you are medically unable to take the Generic medication and the exception is approved by Express Scripts.

There is no deductible for mail-order prescriptions.

Initial orders

There are three ways to order a mail-order prescription:

- Access Express Scripts' website (express-scripts.com/verizon) and follow the instructions to transfer an existing retail prescription to mail
- Send your original prescription and your payment to Express Scripts using a mail order form
- For the fastest service, ask your Doctor to send the prescription directly to Express Scripts by e-prescribing. Have your Doctor call 888.EASYRX1 (888.327.9791) for instructions

Your medication will usually arrive by United States Postal Service mail or UPS within seven days after Express Scripts receives your order.

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

NOTE:
Medications cannot be mailed outside the United States.

Refills

There are three ways to order mail-order refills:

- Access Express Scripts' website (express-scripts.com/verizon) and follow the instructions for refilling prescriptions
- Call Express Scripts at the number listed on your ID card

- Mail your refill slip to Express Scripts using a mail order form

What is covered

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

- Medications that are included in the Formulary
- Medications that require a prescription and that are Medically Necessary. Medically Necessary means appropriate with regard to general medical standards and effective in prevention, diagnosis or treatment according to accepted clinical evidence, as determined by the claims administrator.
- Biologicals, immunization agents and vaccines
- Allergy sera, at a retail pharmacy
- Diabetes therapy medication and supplies available through Express Scripts, including:
  - Medications, insulin, insulin needles, syringes, test strips and lancets
  - Diabetes medications and supplies available through Express Scripts Home Delivery for a single Copayment when dispensed on the same day:
  - Qualified items are:
    - Insulin or other injectable medication to control high blood sugar levels associated with the treatment of diabetes
    - Oral medications to control high blood sugar levels associated with diabetes
    - Syringes or needles used to administer these medications
    - Test strips or lancets
  - Items not intended for coverage in this Copayment relief program are Korlym, Glucagon or Glucagon Emergency Kits, and similar items used to treat low blood sugar.
  - Remember to order your needles, syringes, test strips and lancets together with your diabetes medication(s). You will pay a single Copayment for these items when they are dispensed on the same day.
  - Do not refill diabetes medications and supplies too soon, or else the medication will be shipped at a later date than the needles and syringes, which will result in an additional Copayment.
  - When it's time to renew, prescriptions for diabetic medications and supplies should be written or sent electronically together by your doctor. You will pay a single Copayment for these items when they are dispensed on the same day. Otherwise, you may have to pay separate Copayments.
  - Diabetic medications and supplies ordered separately.
- Medications with special considerations. Some medications in the following treatment categories have limitations or considerations for age, gender or supply amounts.
  - Premenstrual conditions
  - Asthma
  - Erectile dysfunction
  - Acne
  - Flu prevention and treatment
  - Contraceptives
  - Cancer
  - Hormone replacement
- Exempt prescription infant formula when it is Medically Necessary for infants who have been diagnosed with medical or dietary problems

Special purchase requirements for certain medications

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

- Before dispensing medications with the potential of a drug interaction with other drugs, the prescription program will alert the pharmacist who will determine if the Doctor should be contacted
- After clinical reviews are performed, patients who potentially may be overusing highly addictive narcotics may be limited to purchasing their medications at one In-Network Pharmacy of their choice and through mail order

Generic medications

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

Compound medications

Compound drugs are combined or mixed by a pharmacist based on a prescription from a Physician. Once compounded, the combination is not approved by the FDA, so there's no way to confirm the quality, safety and effectiveness. Similarly, compounding kits and pain patches are not reviewed by the FDA so there's no way to confirm their quality, safety and effectiveness. Most compound drugs, compounding kits and pain patches are not covered. For additional information on compound drugs, compounding kits and pain patches, contact Express Scripts at the number listed on your ID card.

Medications that require a coverage review

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

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

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

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

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

- Acne therapy
- Alzheimer’s therapy

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

Quantity dispensing limits

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

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

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

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

What is not covered

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

- Medications not approved by the FDA
- Medications that are excluded under the Formulary
- Medications that states restrict for sale or distribution
- Medications that are not Medically Necessary or that do not treat an accidental Injury, Illness or pregnancy, except those identified under "What Is Covered"
- Therapeutic devices, bandages, heat lamps, braces or artificial appliances. However, the Plan may cover insulin needles and syringes, over-the-counter diabetic supplies (unless covered by Medicare), and diaphragms and IUDs that require a prescription.
- Health and beauty aids and medications for cosmetic purposes, such as Renova, Retin-A or Solage for age spots or as a wrinkle cream, and Propecia or Rogaine for hair loss
- Charges for the administration or injection of any drug
- Medications for experimental use
- Medication covered by Workers' Compensation laws or similar government programs, or for which no charge is made
- Charges covered by Medicare, including both Medicare Part A and Part B – regardless of whether or not you have enrolled in or received Medicare Part A and Part B benefits

- Blood or blood plasma[5]
- Medication you receive in a hospital or outpatient surgical center[5] [6]
- Medication you receive while you are a patient in a skilled nursing facility or similar institution when medications provided by those institutions are covered by a medical plan, including Medicare[5] [6]
- Prescriptions refilled in excess of the number of times the Doctor specified or any refill dispensed after one year from the Doctor's original order
- Mifeprex, for termination of intrauterine pregnancy
- Over-the-counter (OTC) medications and their equivalents available by prescription (except for insulin, diabetic supplies and products included in the Affordable Care Act)
- Ostomy supplies

[5] May be covered under the Verizon Medical Plan. Claims should be submitted to the appropriate claims administrator.
[6] Medications administered while you are an inpatient at a hospital, skilled nursing care facility or similar facility generally are covered under your medical option – not the prescription drug program. However, prescriptions filled at a pharmacy associated with a personal care facility, such as a nursing home, are covered under the prescription program. Benefits are based on whether the retail pharmacy is an in-network or out-of-network pharmacy.

Filing claims

Medical claims

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

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

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

Mental Health and Substance Abuse claims

If you receive in-network care, you do not have to file claims. Anthem Behavioral Health providers automatically will submit claims on your behalf. If you receive care from a provider who is not in the Anthem network (for example, in the event of certain emergencies), you will need to file a claim and send copies of your bills and receipts to Anthem Behavioral Health. See the “Medical plan contacts” section for contact information. Keep in mind that the EPO usually does not cover any out-of-network care, except certain emergency care. If out-of-network care is approved, it will be based on the Maximum Allowed Amount instead of Network Negotiated Fees.

If your claim is denied, you have a right to appeal. See your "Medical Benefits" SPD for information on filing an appeal. See the “Accessing your benefits information” section for information on how to access your SPD.

Prescription drug claims

If you use an In-Network Pharmacy or mail order, you do not have to file claims. You need to show your ID card when you use an In-Network Pharmacy.

If you use an out-of-network pharmacy, you need to submit claims to Express Scripts.

If your claim is denied, you have a right to appeal. See the "Claims and appeals procedures" section in your "Medical Benefits" SPD for information on filing an appeal. See the “Accessing your benefits information” section for information on how to access your SPD.

Pre-authorization for compound medications

You may seek pre-authorization of a prescription for a compound drug. The standards and processes that will apply in that pre-authorization process, including the requirement that your Doctor establish medical necessity, will be equivalent to those that apply to an appeal of the denial of a prescription for a compound drug under the Plan.

Terms to know

Brand-Name Drug

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

Clinically Necessary

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

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

Services and supplies may not be considered Clinically Necessary even if a provider prescribes them.

Copayment (Copay)

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

Custodial Care

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

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

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

- Who recommends, provides or directs the care
- Where the care is provided
- Whether or not the patient, or another caregiver, can be or is being trained to care for himself or herself

Discounted Network Price (DNP)

The price negotiated with a pharmacy by the benefits administrator of the prescription drug program. A covered person pays a portion of this price when he or she purchases medications at a network pharmacy with a prescription drug ID card.

Doctor or Physician

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

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

Educational or Developmental

Educational or Developmental means a service or supply with the purpose of providing training in daily living activities, instruction in scholastic skills such as reading and writing, preparation for an occupation, treatment for a learning disability or promotion of the development beyond any functional level previously demonstrated.

Experimental or Investigational

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

- All phases of clinical trials for non life-threatening diseases or conditions
- All treatment protocols based on or similar to those used in clinical trials for non life-threatening diseases or conditions
- Drugs approved by the FDA under its Treatment Investigational New Drug regulation
- FDA-approved drugs used for unrecognized treatment indications

A drug, device, procedure or treatment is determined to be Experimental or Investigational if:

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

Effective as of January 1, 2014, a covered person will be eligible for coverage of routine costs for items and services furnished in connection with a covered person's participation in an approved clinical trial to the extent required by the Affordable Care Act and related guidance or as otherwise required as specified by the Plan. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition.

Formulary

The Formulary is a list of preferred medications that are either more effective at treating a particular condition than other medications in the same class, or as effective as and less costly than similar medications. Non-preferred medication may be covered under the Formulary, but at a higher cost. Certain medications are excluded from the Formulary unless approved in advance through a Formulary exception review on the basis that the drug requested is (1) Medically Necessary and essential to your health and safety and/or (2) all Formulary medications comparable to the excluded medication have been tried by you. If your Doctor believes that an excluded medication meets the requirements described above, the Doctor should take the necessary steps to initiate a Formulary exception review which is managed by Express Scripts. If approved through this process, the applicable coinsurance would apply; however, if not approved, you will be responsible for the full cost of the drug. The Formulary is updated periodically and subject to change.

Generic Drug

A prescribed medication that is chemically equivalent to a Brand-Name medication that no longer is under patent protection.

Illness

A non-occupational bodily disorder.

Injury

A non-occupational bodily Injury.

In-Network Retail Pharmacy

A retail pharmacy that belongs to the Express Scripts National Network.

Maximum Allowed Amount

For covered services you receive from an out-of-network provider under the EPO, the Maximum Allowed Amount is 240 percent of the national Medicare schedule.

Medically Necessary

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

Mental Health Disorders and Treatment

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

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

The EPO option covers Mental Health Treatment for Mental Health Disorders, Illness, emotional disturbance or behavioral problems that are diagnosed by a licensed mental health professional.

Morbid Obesity

Surgery to assist in weight loss (bariatric surgery) is a covered benefit. This surgery requires pre-certification and is also subject to review for medical necessity according to Anthem's medical policy.

This surgery is considered Medically Necessary when the member meets Anthem's medical policy, including but not limited to:

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

Additional information regarding requirements for this surgery can be obtained from a Total Health Total You Nurse, who can address your unique situation.

Network Negotiated Fee (NNF)

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

Participating EPO Providers

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

Substance Abuse

The non-medical or recreational use of substances that alter the state of consciousness

Total Health Total You Nurse

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

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

Treatment Facility

A Treatment Facility must meet all of these conditions:

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

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

- Used primarily as a convalescent facility, rest facility, nursing facility or facility for the aged

- Furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living
- Operated primarily as a school