



Our plans fit your plans



ClearProtection<sup>SM</sup>  
CoreShare<sup>SM</sup>



# Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on — coverage designed to help fit your budget, and your way of life.

For over 40 years, Anthem has provided health care coverage and security to our Nevada neighbors. We're pleased to offer these same individual health care plans with the added benefits and features of the Affordable Health Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

## Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **Optional dental and term life insurance.** To enhance your health and your family's financial future, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.
- **Choose your doctor and compare your health care costs at anthem.com.** Manage your health care in a simple and easy way at anthem.com. Once you're a member, all you have to do is register at anthem.com and start feeling better about your choices with features like:
  - **Find a Doctor:** Use our online Provider Directory to find hospitals, pharmacies and other specialists in your area — and check whether they are cost-saving network providers — all at the click of a mouse.
  - **Anthem Care Comparison:** Save time and money by comparing the quality and safety of providers as well as the cost of common procedures at health care facilities in your area.
  - **Zagat Health Surveys:** See what other patients have said about the doctors and hospitals you're considering. Add your own doctor recommendation, too!

## Why do you need health care coverage?

These days, an average stay in the hospital can cost more than \$30,000.\* The financial risk you take without health coverage just isn't worth it. Not only does health coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

\*Based on 2009 weighted national estimates from HCUP National Inpatient Sample (NIS), Agency for Healthcare Research and Quality (AHRQ), based on data collected by Individual states and provided to AHRQ by the states. (Average stay of 4.6 days; average cost to uninsured of \$30,655.)

Register at anthem.com and have a wealth of health information right at your fingertips.

# Some definitions so we're all on the same page

**Network Discounts:** With Anthem Blue Cross and Blue Shield you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members – similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 2,500 doctors and nearly 40 hospitals, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

**Cost-Sharing:** The costs of medical care today can be staggering. Health care coverage from Anthem Blue Cross and Blue Shield can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the costs, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

**Deductible** is the amount you have to pay each calendar year (annually) for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

**Coinsurance** is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

**Copayment** (or Copay) is a specific dollar amount you have to pay for certain covered services.

**Out-Of-Pocket Maximum** is the most that you would pay in a calendar year for deductible and coinsurance for network covered services. Once you reach this maximum, the plan pays at 100% for most services for the rest of the calendar year.

**Prescription Drugs** are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

**Generic Drugs** are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

**Brand Name Drugs** are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

**Specialty Drugs** are typically high cost, scientifically engineered drugs used to treat complex, chronic conditions. They require special handling and usually must be shipped directly to the user.

**Formulary** is a list of prescription drugs our health care plans cover. They include generic, brand name, and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

# ClearProtection<sup>SM</sup>

## Is this the right plan for you?

ClearProtection is one of our lower-priced plans with an innovative plan design that helps limit your share of the costs for major medical expenses, such as surgery and hospitalizations. In addition:

- You'll have immediate benefits for your first two doctors' office visits.
- There are two deductibles that work together to help you meet your out-of-pocket maximum.
- Once your out-of-pocket maximum is met, the plan pays 100% of the costs for most network covered services.

### ClearProtection Plan Highlights

This plan offers a valuable combination of affordable coverage with some immediate benefits, plus a broad range of benefits once the out-of-pocket maximum is met.

#### Features:

- Some of our lowest monthly rates and immediate coverage for first two doctors' office visits.
- Access to discounts on ALL covered services from network providers while meeting your out-of-pocket maximum.
- 100% coverage for most network covered services once your out-of-pocket maximum is met.
- Coverage for generic and brand name prescription drugs.
- Preventive care benefits help focus on keeping you healthy.

#### You should know:

- This plan features two deductibles that work together to help you meet your total out-of-pocket maximum.
- Deductibles for Network and Non-Network covered services are the same dollar amount and accumulate separately. The same is true for Out-of-Pocket Maximums.
- This plan has its own Drug Formulary.
- Maternity benefits are not included with this plan.

## Prescription Drug Coverage

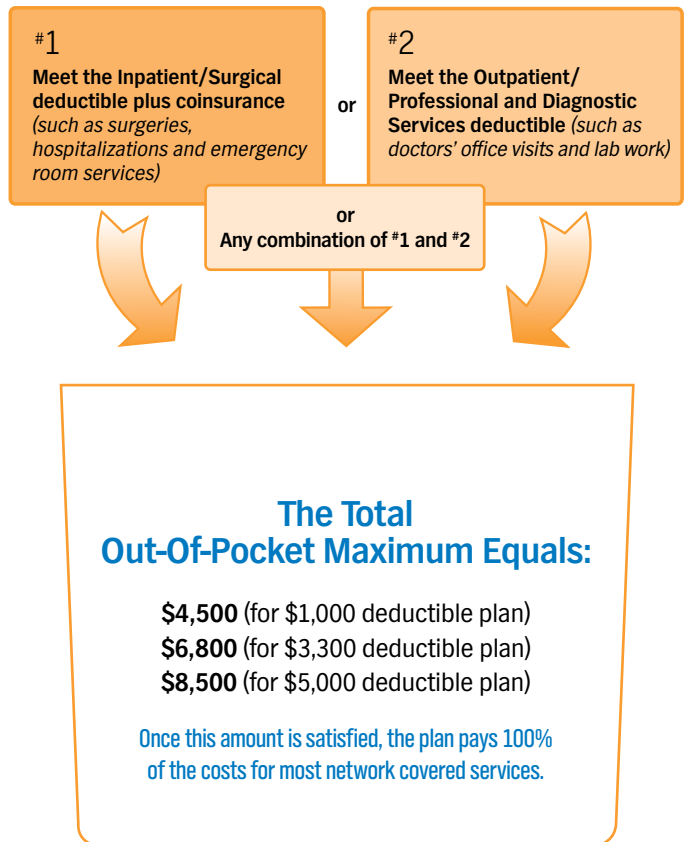
The ClearProtection covers both generic and brand name prescription drugs. This plan also uses a special Formulary.

## How ClearProtection Works

### ClearProtection has two deductibles:

1. **Inpatient/surgical services**  
This is the lower of the two deductibles to help you access benefits faster for these higher-cost services.
2. **Outpatient/professional and diagnostic services**  
This deductible is equal to your out-of-pocket maximum. So even if you only use outpatient services, once you meet this deductible, you will have also met your out-of-pocket maximum.

**These two deductibles work together to help you reach your total out-of-pocket maximum. Depending on your health care needs, you can satisfy your total out-of-pocket maximum in any of the following ways:**



**Note: Deductibles and Out-of-Pocket Maximums are based on a calendar year (January 1 - December 31).**

## Benefits

## ClearProtection<sup>SM</sup>

### Calendar Year Deductible

Deductibles for Network and Non-Network covered services are the same dollar amount and accumulate separately.

|                             |         |          |          |   |
|-----------------------------|---------|----------|----------|---|
| Individual                  | \$1,000 | \$3,300  | \$5,000  | For Inpatient/Surgical and Emergency Room Services  |
|                             | \$4,500 | \$6,800  | \$8,500  | For Outpatient/Professional and Diagnostic Services |
| Family                      | \$2,000 | \$6,600  | \$10,000 | For Inpatient/Surgical and Emergency Room Services  |
|                             | \$9,000 | \$13,600 | \$17,000 | For Outpatient/Professional and Diagnostic Services |
| Network Coinsurance Options | 30%     | 30%      | 30%      | For Inpatient/Surgical and Emergency Room Services  |
|                             | 0%      | 0%       | 0%       | For Outpatient/Professional and Diagnostic Services |

### Calendar Year Out-of-Pocket Maximum

All covered services will apply toward either your in-network or out-of-network out of pocket maximum amount. Once you've met the applicable out of pocket maximum, your plan pays 100% of allowable charges.

|            |         |          |          |   |
|------------|---------|----------|----------|---|
| Individual | \$4,500 | \$6,800  | \$8,500  | (these amounts include the deductibles) |
| Family     | \$9,000 | \$13,600 | \$17,000 | (these amounts include the deductibles) |

How family deductibles and family out-of-pocket maximums work

Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.

Plan Lifetime Maximum

None

### Covered Services

#### Your Share of Costs (after deductible, if applicable)

|   |  |
|---|--|
| Doctors' Office Visits  | <b>NETWORK:</b> First 2 office visits per member: \$40 copay, deductible waived.<br>Additional Office Visits: 100% coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible<br><b>NON-NETWORK:</b> 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible   |
| Professional and Diagnostic Services<br>(X-ray, lab, anesthesia, surgeon, etc.) | <b>NETWORK:</b> Inpatient: 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible<br>Outpatient: 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible<br><b>NON-NETWORK:</b> Inpatient: 50% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible<br>Outpatient: 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible |
| Inpatient Services<br>(overnight hospital/facility stays)                       | <b>NETWORK:</b> 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible<br><b>NON-NETWORK:</b> 50% coinsurance after deductible, then 0% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible   |
| Outpatient Services<br>(without overnight hospital/facility stays)              | <b>NETWORK:</b> Surgery: 30% coinsurance after satisfying Inpatient/Surgery and Emergency Room Services deductible<br>Other Services: 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible<br><b>NON-NETWORK:</b> 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible   |
| Emergency Room Services   | <b>NETWORK OR NON-NETWORK:</b> 30% coinsurance PLUS \$100 Emergency Room copay (copay waived if admitted); then 0% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible  |
| Preventive Care Services  | Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.<br><b>NETWORK:</b> 0% coinsurance, not subject to either deductible<br><b>NON-NETWORK:</b> Nationally recommended preventive services: 50% coinsurance, not subject to Outpatient/Professional and Diagnostic Services deductible   |
| Maternity   | Not Covered  |
| Optional Coverage (at additional cost)  | Dental, Life, Autism benefits  |

### Prescription Drug Coverage

#### ClearProtection<sup>1</sup>

Retail Drugs (and Mail Order Drugs when available)

**NETWORK:**  
Tier 1 (Generic drugs): \$15 copay  
\$7,500 annual Prescription Drug deductible per member for Tier 2/Specialty drugs applies before the following:  
• Tier 2 (Formulary Brand name drugs): \$35 copay  
• Tier 3/Specialty: 25% coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), for network only and in addition to \$7,500 annual deductible.  
• For Drugs Not on Formulary: Not covered, discounts apply.  
**NON-NETWORK:** Same benefits as network plus any difference in cost between the actual charges and Anthem's allowed amount.

Optional Drug Coverage (when available)

Not Available

Other Covered Benefits include but are not limited to:

Ambulance, Home Health Care, Physical/Occupational Therapy, Urgent Care

**IMPORTANT:** This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Policy. In the event of a conflict between the Policy and this Benefit Guide, the terms of the Policy will prevail.

<sup>1</sup> ClearProtection has its own Plan Formulary.

**NOTES:** Discounted network rates apply for network covered services. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount. Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Policy.

## Is this the right plan for you?

If you're looking for a simple plan design with some of our lowest rates, CoreShare could be the plan that's right for you. CoreShare offers a range of deductibles and higher cost-sharing helps lower your monthly premiums.

### CoreShare Plan Highlights

This plan can be ideal for individuals who want affordable protection against significant medical expenses.

#### Features:

- A simple plan design with some of our lowest monthly rates.
- Higher percentage of member cost-sharing in exchange for lower premiums.
- Once the deductible is met, we'll share 50% of the costs at our negotiated rates up to \$3,500, then we'll cover the rest for most covered services.
- Preventive care benefits help focus on keeping you healthy.
- Coverage for prescription drugs.

#### You should know:

- This plan has its own Drug Formulary.
- Maternity benefits are not included with this plan.

**Other Optional Coverage:** You can add more protection for you and your family by purchasing optional dental and life insurance or autism benefits. See the information at the back of this brochure or ask your Anthem agent for more details.

## Prescription Drug Coverage

The cost of prescription drugs can be staggering so CoreShare includes prescription drug coverage to help you manage those costs.

- **Drug Formulary:** This is a special list of prescription drugs the CoreShare plan covers. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes from the Plan Formulary posted at [www.wellpointnextx.com/Formulary1](http://www.wellpointnextx.com/Formulary1).
- **Tier 1:** These drugs have the lowest copay and include generic medications.
- **Tier 2:** These drugs have a higher copay than those in Tier 1 and include formulary brand name medications.
- **Tier 3/Specialty:** These drugs have a higher copay or coinsurance than those in Tier 2 and may include specialty drugs which are typically high-cost, scientifically engineered drugs.

## How to Customize your CoreShare Plan

With CoreShare, you have some choice and flexibility to change the plan to better meet your needs. CoreShare offers a choice of:

**Deductible:** You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

**Coinsurance:** CoreShare offers a choice of coinsurance levels depending on the deductible you choose. Choosing a higher deductible can take your coinsurance for covered services to zero if you'd like to pay more toward your calendar year deductible first.

**Facility Copayment:** Similar to the coinsurance percentage, if you choose a \$3,500 or higher deductible, you can eliminate the facility copayment requirement, and you will only be responsible for any deductible or coinsurance. Otherwise, there is a copayment that will apply for inpatient hospital stays or outpatient surgeries.

## Benefits

### Calendar Year Deductible

|                             |              |         |         |         |         |          |          |
|-----------------------------|--------------|---------|---------|---------|---------|----------|----------|
| Individual                  | NETWORK:     | \$750   | \$1,500 | \$2,500 | \$3,500 | \$5,000  | \$7,500  |
|                             | NON-NETWORK: | \$750   | \$1,500 | \$2,500 | \$3,500 | \$5,000  | \$7,500  |
| Family                      | NETWORK:     | \$1,500 | \$3,000 | \$5,000 | \$7,000 | \$10,000 | \$15,000 |
|                             | NON-NETWORK: | \$1,500 | \$3,000 | \$5,000 | \$7,000 | \$10,000 | \$15,000 |
| Network Coinsurance Options |              | 50%     | 50%     | 50%     | 50%     | 50%      | 50%      |

### Calendar Year Out-of-Pocket Maximum

|            |              |          |          |          |          |          |          |
|------------|--------------|----------|----------|----------|----------|----------|----------|
| Individual | NETWORK:     | \$3,500  | \$3,500  | \$3,500  | \$3,500  | \$3,500  | \$3,500  |
|            | NON-NETWORK: | \$7,750  | \$8,500  | \$7,500  | \$7,500  | \$7,500  | \$7,500  |
| Family     | NETWORK:     | \$7,000  | \$7,000  | \$7,000  | \$7,000  | \$7,000  | \$7,000  |
|            | NON-NETWORK: | \$15,500 | \$17,000 | \$15,000 | \$15,000 | \$15,000 | \$15,000 |

How family deductibles and family out-of-pocket maximums work

Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined. (See footnote below regarding separate facility copay for \$750, \$1,500 and \$2,500 deductible plans)

### Plan Lifetime Maximum

None

## Covered Services

### Doctors' Office Visits

NETWORK: 50% coinsurance  
NON-NETWORK: 50% coinsurance

### Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

NETWORK: 50% coinsurance  
NON-NETWORK: 50% coinsurance

### Inpatient Services (overnight hospital/facility stays)

NETWORK: 50% coinsurance PLUS \$500 facility copay<sup>1</sup> per day up to the first 3 days (with \$750, \$1,500, \$2,500) 50% coinsurance (with \$3,500, \$5,000, \$7,500);  
NON-NETWORK: 50% coinsurance PLUS \$500 facility copay<sup>1</sup> per day up to the first 3 days (with \$750, \$1,500, \$2,500) 50% coinsurance (with \$3,500, \$5,000, \$7,500);

### Outpatient Services (without overnight hospital/facility stays)

NETWORK: 50% coinsurance PLUS \$200 facility copay<sup>1</sup> per admission (with \$750, \$1,500, \$2,500) 50% coinsurance (with \$3,500, \$5,000, \$7,500);  
NON-NETWORK: 50% coinsurance PLUS \$200 facility copay<sup>1</sup> per admission (with \$750, \$1,500, \$2,500) 50% coinsurance (with \$3,500, \$5,000, \$7,500);

### Emergency Room Services

NETWORK and NON-NETWORK: 50% coinsurance

### Preventive Care Services

Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.  
NETWORK: 0% coinsurance, not subject to deductible  
NON-NETWORK: Same as network benefits but 50% coinsurance

### Maternity

Not Covered

### Optional Coverage (at additional cost)

Dental, Life, Autism benefits

## Prescription Drug Coverage

### Retail Drugs (and Mail Order Drugs when available)

NETWORK:  
Tier 1 (Generic Drugs): \$15 copay  
\$7,500 annual Prescription Drug deductible per member applies before the following:  
• Tier 2 (Formulary Brand Name Drugs): \$35 copay  
• Tier 3/Specialty: 25% coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$7,500 annual deductible.  
• For Drugs Not on Formulary: Not covered, discounts apply  
NON-NETWORK: Same benefits as network plus any difference in cost between the actual charges and Anthem's allowed amount.

### Optional Drug Coverage (when available)

Not Available

### Other Covered Benefits include but are not limited to:

Ambulance, Chiropractic Services, Home Health Care, Severe Mental Health, Physical/Occupational Therapy, Urgent Care

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Certificate and/or Summary of Benefits. In the event of a conflict between this Benefit Guide and either the Certificate or Summary of Benefits, the Certificate and/or Summary of Benefits will prevail.

1 Facility Copay only applies to \$750, \$1,500 and \$2,500 deductible plans. Facility Copay does not accumulate toward the deductible or out-of-pocket maximum. Facility Copay is still required even if out-of-pocket maximum has been met. Balance of covered charges subject to deductible and coinsurance. No additional Facility Copay if readmitted to the same facility within 72 hours of the initial admission.

2 CoreShare has its own Plan Formulary.

#### NOTES:

- Discounted network rates apply for network covered services.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.
- For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
- Coinsurance to network and non-network providers applies to annual out-of-pocket maximum except where specifically noted in the Certificate.

# Dental Coverage

Our Anthem Blue Dental PPO plan includes coverage for the basics, plus certain services like crowns, root canals and dentures. If you need a dental plan that offers important preventive services and a broad range of benefits, this could be the right plan for you.



Give yourself every advantage...

Good health, a bright smile and financial support.

## Save money by using our dental network

We have more than 2,100 participating dental PPO dentist locations in Nevada to choose from. While our dental PPO plan allows you to go to *any* dentist, you may save the most money when you choose one of the dentists in our PPO provider network. Even better, when you visit a network dentist, there is no deductible or member coinsurance for covered diagnostic or preventive services. For basic and major services, the calendar-year deductible is \$50 per person (up to three deductibles per family) and must be satisfied before we will pay any benefits.

### Diagnostic and Preventive Care

Coverage for routine check-ups, X-rays and cleanings begins the day your policy is effective.

| Diagnostic and Preventive Care   |           |               |
|--|-----------|---------------|
| Procedure  | Plan Pays |               |
|  | Network   | Non-network   |
| Periodic oral exams, routine cleanings and X-rays<br><small>(cleanings limited to two per member per year)</small> | 100%      | Fee Schedule* |

### Basic Dental Care

Coverage for basic dental care begins after six months of continuous coverage.

| Basic Dental                                       |                        |
|--|------------------------|
| Procedure  | Plan Pays              |
|  | Network or Non-network |
| Fillings (one surface, permanent)                  | \$42                   |
| Fillings (two surfaces, permanent)                 | \$54                   |
| Extraction, simple (erupted tooth or exposed root) | \$39                   |

### Major Dental Care

Coverage for major dental care begins after 12 months of continuous coverage.

| Major Dental                      |                        |
|-----------------------------------|------------------------|
| Procedure                         | Plan Pays              |
|                                   | Network or Non-network |
| Scaling/root planing per quadrant | \$43                   |
| Root Canal (one canal)            | \$127                  |
| Crown (except stainless steel)    | \$225                  |
| Complete denture (upper or lower) | \$300                  |

\*For more details and a copy of our non-network fee schedule, please contact your Anthem agent.

### Calendar Year Maximum Benefit

During each calendar year, the Anthem Blue Dental PPO plan provides up to \$1,000 of benefits for each enrolled member.



# Term Life Insurance

Losing a loved one is painful enough without having to worry about finances. Give your family extra support with term life insurance from Anthem Life Insurance Company.

If you're accepted for coverage on one of our health care plans, you'll automatically be approved for our term life insurance. Plus, there are no medical exams or additional enrollment forms to worry about. It's that simple.

| Term life monthly rates |                  |                  |                  |                  |                   |
|-------------------------|------------------|------------------|------------------|------------------|-------------------|
| Age                     | \$15,000 Benefit | \$25,000 Benefit | \$50,000 Benefit | \$75,000 Benefit | \$100,000 Benefit |
| 1-18                    | \$1.50           | \$2.50           | N/A              | N/A              | N/A               |
| 19-29                   | \$2.80           | \$4.65           | \$9.30           | \$11.25          | \$13.00           |
| 30-39                   | \$3.25           | \$5.40           | \$10.80          | \$13.50          | \$16.00           |
| 40-49                   | \$7.50           | \$12.50          | \$25.00          | \$33.75          | \$42.00           |
| 50-59                   | \$20.90          | \$34.80          | \$69.60          | \$97.50          | \$125.00          |
| 60-64                   | \$29.40          | \$49.00          | \$98.00          | \$142.50         | \$185.00          |

Up to \$100,000 in life insurance with no medical exams and no blood work required. Just check a box on your application.

It's that simple.



# Additional Information

## "No Obligation" review period

After you enroll in an Anthem plan, you'll receive a Certificate that explains the terms and conditions of coverage, including the plan's exclusions and limitations. You have 30 full days to examine your plan's features. During that time, if you're not fully satisfied, you may decline coverage by returning your Certificate along with a letter notifying us that you want to discontinue coverage. You'll receive a full refund of any premium you've paid, less any claims we've paid on your behalf. Certificates are available to examine before enrolling. Ask your agent or Anthem.

## Save time with automatic premium payment

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health care plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.



## Ready to choose a plan?

- After reviewing all the materials included with this brochure, contact your Anthem agent.
- Ask questions. If you aren't sure about how a plan works or have additional questions, your agent will help you.
- Fill out an application. The quickest and easiest way to complete an application is online and your agent can assist you. Or your agent can provide you with instructions for mailing or faxing your application.

If you have questions or want more details about your options, call your Anthem agent today!



# Individual health coverage. Your plans. Your choices.

## Make sure you have all the facts

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan[s] described — including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this brochure from your computer, it should be at the end. If you did not receive a copy of the Coverage Details, be sure to contact your Anthem agent.

**This brochure is intended as a brief summary of benefits and services; it is not your Certificate. If there is any difference between this brochure and your Certificate, the provisions of the Certificate will prevail. Benefits and premiums are subject to change.**

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

## Ready to enroll?

**Call your Anthem agent today!**

To view a Summary of Benefits and Coverage please visit [healthcare.gov](http://healthcare.gov).

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. Life insurance products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

# Nevada Coverage Details

Things you need to know before you buy...

SmartSense® Plus, CoreShare,™ Premier, Lumenos® HSA Plus and ClearProtection™

**Before choosing a health care plan, please review the following information, along with the other materials enclosed.**

## To enroll, you must be:

- At least 19 years of age (not to exceed 64 3/4 years of age) to be eligible as the main subscriber. Child dependents under the age of 19 must apply and be enrolled with at least one parent or legal guardian (age 19 years or older)
- A permanent legal resident of Nevada

## Medical Underwriting Requirement

We believe the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem offers various levels of coverage. To determine individual medical risk factors, all enrollments are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium rate
- You may be offered the plan you selected at a higher rate
- You may not qualify for the plan(s) listed in the brochure
- You may be offered an alternate plan

If you have a significant medical condition and don't qualify for the plan you've chosen or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

## Rate Determinations

For Individual policies, rates are determined as follows:

- Rates are based on age, gender, benefit plan, family size, geographic location and tobacco use.
- For families with more than three children, the family rate is capped at three children.
- When a member or spouse attains an age that requires a rate change to a new category, the adjustment will be made on the policy anniversary date and the premium will be automatically adjusted to the new rate.
- Rates are subject to change with 60-day written notice.

## Waiting Periods

For applicants age nineteen (19) and older there is a 12-month waiting period for coverage of any health condition, whether physical or mental, for which medical advice, diagnosis, care or treatment

was recommended or received within 6 months preceding the coverage effective date. If you apply for coverage within 63 days of terminating your membership with another 'creditable' health care benefits plan, you may use your prior coverage for credit toward the 12-month waiting period. Anthem will credit the time you were enrolled in the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen (19). Consult with your Anthem agent or representative if you have a question about the underwriting process.

## Guaranteed Renewability Of All Individual Health Policies

Anthem will not cancel or refuse to renew any Individual policy, except for the following reasons:

- Nonpayment of premium
- Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the insured
- Anthem elects to discontinue offering all Individual policies
- The state insurance commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders
- The state insurance commissioner finds that the product form is obsolete and is being replaced with comparable coverage

## Nevada Summary Of Benefits Form

Nevada law requires carriers to make available a Nevada Summary of Benefits Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, on oral or written request, within three business days to any person who is interested in coverage under, or who is covered by, a health care benefits plan of the carrier. If you would like a copy of the state mandated Nevada Summary of Benefits Form, which provides information on health plan benefits, provider contract arrangements and other information, please contact your Anthem agent. For complete details about benefits, procedures, limitations and exclusions, please refer to the Summary of Benefits Form and Certificate. In the event of a conflict between anything printed in this document and the Certificate, the terms of the Certificate will prevail.

## Terms Of Coverage

Coverage remains in force as long as you pay the required premiums on time and for as long as you remain eligible for membership. Coverage will cease if you become ineligible due to:

- Residency requirements and/or
- Duplicate Individual coverage with Anthem

We may change rates with at least 60-day advance written notice. We may change coverage or benefits with 90-day advance written notice. Anthem does not change coverage or rates unless the change applies to all covered persons of the same class.

## Access To The Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Anthem or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is  
50 Braintree Hill Park, Suite 400  
Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

Anthem, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

### Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that:

- 1) the procedure is medically necessary and
- 2) the procedure meets your health care plan's specific guidelines prior to being performed.

Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

### Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

### Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification).

Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

### Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

### Medical Exclusions And Limitations

The following information will help you understand what your health care plan does not include before you enroll. This is an overview only. For a complete list of exclusions and limitations, you can request a copy of the plan's Summary of Benefits Form and Certificate. Just ask your Anthem agent for a copy.

### Our Plans Do Not Cover

- Normal maternity and pregnancy care
- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state, federal or foreign government
- Services or supplies not specifically listed as covered in the Certificate
- Services received before your plan effective date or after coverage ends, except as stated in your Certificate
- Personal comfort items
- Custodial care
- Services or supplies related to sex change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation
- Cosmetic surgery
- Services primarily for weight reduction
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Certificate
- Routine exams and immunizations related to sports, insurance, condition of employment, for licensing, school, church or camp or routine care received in the emergency room.
- Infertility services
- Eyeglasses or contact lenses
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Certificate
- Services received for mental and nervous disorders and substance abuse, except as specifically stated in the Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Certificate
- Nutritional counseling, food, or dietary supplements except for formulas and special food products to prevent complications of phenylketonuria (PKU) and inherited enzymatic disorders as stated in the certificate
- Genetic testing
- Hearing aids or routine hearing tests
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Certificate
- Outpatient speech therapy, except as specifically stated in the Certificate
- Private duty nursing
- For ages 19 and older, services or supplies related to a pre-existing condition, for applicants age nineteen and older

- Educational services except as provided for or arranged by Anthem
- Telephone or Internet consultations
- Any services received by Medicare benefits without payment of additional premium
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Services or supplies that are not medically necessary

**Premier** and **SmartSense Plus** plans do not cover obesity surgery.

**Lumenos Plus** does not cover skilled nursing facility care.

### Dental Benefits Which Are Not Covered By Anthem Dental

The following information will help you understand what your dental care plan does not include before you enroll. This is an overview only. For a complete list of exclusions and limitations, you can request a copy of the Dental Plan Certificate.

### Limitations

This is a partial list of plan limitations. Please see the Individual Dental Plan Contract for a complete list

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19
- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period. Periapical X-rays are limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films once per calendar year
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any five years
- Replacement of a fixed or removable prosthesis if such replacement occurs within five years of the original placement, unless the denture is a stayplate used during the healing period for recently extracted anterior teeth

### Exclusions

This is a partial listing of plan exclusions. Please see the Individual Dental Plan Contract for a complete list.

- Prescribed drugs, pre-medication or analgesia
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism
- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any five-year period, whether under this Contract or under any prior dental coverage
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

### Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem agent to request them.

**The Summary of Benefits Form and/or Certificate are also available for you to examine before enrolling. Ask your Anthem agent or Anthem.**

Nevada Individual CoreShare PPO 750; 1,500; 2,500; 3,500;  
5,000; 7,500  
Summary of Benefits



This summary provides you with the deductible, coinsurance, and a brief description of your benefits. For more complete information, see your certificate or call Anthem's customer service department toll free at (888) 231-5046. **Coinsurance options reflect the percentage of the allowable charge the covered person will pay.**

|   | In-Network   |  | Out-of-Network   |  |
|---|--|--|--|--|
| <b>Medical Deductible</b><br>Applicable only to specified services (Not combined for In-Network and Out-of-Network)<br><br>Hospital copayments will not apply towards the deductible.   | <b>Individual:</b><br>\$750, \$1,500,<br>\$2,500, \$3,500,<br>\$5,000, \$7,500   | <b>Family Maximum:</b><br>\$1,500, \$3,000,<br>\$5,000, \$7,000,<br>\$10,000, \$15,000 | <b>Individual:</b><br>\$750, \$1,500,<br>\$2,500, \$3,500,<br>\$5,000, \$7,500   | <b>Family Maximum:</b><br>\$1,500, \$3,000,<br>\$5,000, \$7,000,<br>\$10,000, \$15,000 |
|   | Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.  |  | Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.  |  |
| <b>Out-of-Pocket Annual Maximum</b><br>The Out-of-Pocket Annual Maximum includes the deductible but is not combined for in- and out-of-network.<br><br>Hospital copayments will not apply towards the out-of-pocket annual maximum, and will continue to be required after the out-of-pocket annual maximum has been met. | <b>Individual:</b><br>\$4,250, \$5,000,<br>\$6,000, \$7,000,<br>\$8,500, \$11,000  | <b>Family:</b><br>\$8,500, \$10,000,<br>\$12,000, \$14,000,<br>\$17,000, \$22,000      | <b>Individual:</b><br>\$8,500, \$10,000,<br>\$10,000, \$11,000,<br>\$12,500, \$15,000  | <b>Family:</b><br>\$17,000, \$20,000,<br>\$20,000, \$22,000,<br>\$25,000, \$30,000     |
|   | Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no further copayments or coinsurance will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum. |  | Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no further copayments or coinsurance will be required for all enrolled members for the remainder of that year, <b>except</b> for charges in excess of the Maximum Benefit Allowance and where specifically noted in the certificate. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum. |  |

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| Services  | In-Network after Deductible   | Out-of-Network after Deductible   | Additional Information  |
|---|---|---|---|
| <p><b>Physician Visits</b><br/>Inpatient/Outpatient<br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans:</p> <p>Office Visit<br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans:</p>   | <p>50% coinsurance.</p> <p>50% coinsurance.</p>   | <p>50% coinsurance.</p> <p>50% coinsurance.</p>   | <p>Services covered as part of an office visit include:</p> <ul style="list-style-type: none"> <li>• History (gathering of information on an illness or injury)</li> <li>• Examination</li> <li>• Medical decision making (the physician's actual diagnosis and treatment plan)</li> </ul> <p>All other covered professional services, including, but not limited to laboratory, X-ray, radiology and pathology services are subject to applicable deductible, coinsurance, or cost sharing. Please see the Professional Services section of the certificate for a full description of covered professional services.</p> |
| <p><b>Preventive Care</b><br/>Preventive Care Services in this section shall meet requirements as determined by federal and state law. These services fall under four broad categories as shown below:</p> <ol style="list-style-type: none"> <li>1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: <ul style="list-style-type: none"> <li>• Breast cancer;</li> <li>• Cervical cancer;</li> <li>• Colorectal cancer;</li> <li>• High Blood Pressure;</li> <li>• Type 2 Diabetes Mellitus;</li> <li>• Cholesterol;</li> <li>• Child and Adult Obesity.</li> </ul> </li> <li>2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;</li> <li>3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and</li> <li>4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.</li> </ol> | <p>Many In-Network preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member. That means Anthem pays 100% of the Allowed Charge.</p> | <p>50% coinsurance<br/>30% coinsurance<br/>after deductible, plus all charges in excess of the maximum benefit allowance.</p> <p>50% coinsurance<br/>30% coinsurance<br/>after deductible, plus all charges in excess of the maximum benefit allowance.</p> | <p>Professional services are services provided during a physician office-based visit, include, but are not limited to laboratory, X-ray, radiology and pathology services.</p> <p>Please see the Professional Services section of the certificate for a full description of covered preventive care services.</p>   |

| <b>Services</b>   | <b>In-Network<br/>after Deductible</b>   | <b>Out-of-Network<br/>after Deductible</b>   | <b>Additional Information</b>   |
|---|--|--|---|
| <b>Diagnostic Services, Laboratory, Pathology, and X-ray</b><br>Inpatient/Outpatient<br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans:  | 50% coinsurance.   | 50% coinsurance.   | Services billed by a hospital are included in the hospital inpatient/outpatient benefits.   |
| <b>Maternity Care</b>   | Not covered  | Not covered  | Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.   |
| <b>Physical Rehabilitation</b><br>(Physical therapy, occupational therapy, cardiac rehabilitation, and spinal manipulation)<br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans:   | 50% coinsurance.   | 50% coinsurance.   | Physical rehabilitation is limited to twenty four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined.<br><br>Benefits are paid up to 36 visits for cardiac rehabilitation. The program must start within three months of a major cardiac event and be completed within six months of the major cardiac event. |
| <b>Speech Therapy</b><br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans:   | 50% coinsurance.   | 50% coinsurance.   | Benefits are paid up to twenty (20) visits per calendar year; in- and out-of-network combined.  |
| <b>Spinal Manipulations</b>   | Covered under Physical Rehabilitation as specified above.  | Covered under Physical Rehabilitation as specified above.  |   |
| <b>Acupuncture</b>  | Not Covered  | Not Covered  |   |
| <b>Hospital Care</b><br>a) Inpatient<br>For \$750, \$1,500, \$2,500 plans:<br><br>For \$3,500, \$5,000 and \$7,500 plans:<br><br>b) Outpatient Surgery, Outpatient Non-emergency and Ambulatory Surgery Center<br>For \$750, \$1,500, \$2,500 plans:<br><br>For \$3,500, \$5,000 and \$7,500 plans: | \$500 inpatient hospital copayment per day up to three (3) days per admission, plus 50% coinsurance after deductible.<br><br>50% coinsurance.<br><br>\$200 outpatient hospital copayment per visit, plus 50% coinsurance after deductible.<br><br>50% coinsurance. | \$500 inpatient hospital copayment per day up to three (3) days per admission, plus 50% coinsurance after deductible, and all charges in excess of the maximum benefit allowance.<br><br>50% coinsurance.<br><br>\$200 outpatient hospital copayment per visit, plus 50% coinsurance after deductible, and all charges in excess of the maximum benefit allowance.<br><br>50% coinsurance. | Hospital copayments will not apply towards the deductible or out-of-pocket annual maximum, and will continue to be required after the out-of-pocket annual maximum has been met.  |
| <b>Emergency Care</b><br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans:   | 50% coinsurance.   | 50% coinsurance.   |   |

| <b>Services</b>   | <b>In-Network<br/>after Deductible</b>          | <b>Out-of-Network<br/>after Deductible</b>      | <b>Additional Information</b>   |
|---|---|---|---|
| <p><b>Ambulance Services</b><br/>Ground Services/Air Services</p> <p><b>In the event of a medical emergency</b><br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p> <p><b>Other than in a medical emergency</b><br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p>   | <p>50% coinsurance.</p> <p>50% coinsurance.</p> | <p>50% coinsurance.</p> <p>50% coinsurance.</p> | <p>Benefits are paid for medically necessary ground or air ambulance transportation.</p>  |
| <p><b>Alcohol and Drug Abuse</b><br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p>   | <p>50% coinsurance.</p>                         | <p>50% coinsurance.</p>                         |   |
| <p><b>Severe Mental Illness</b><br/>(Severe mental illnesses are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder)</p> <p>a) Inpatient<br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p> <p>b) Outpatient<br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p> | <p>50% coinsurance.</p> <p>50% coinsurance.</p> | <p>50% coinsurance.</p> <p>50% coinsurance.</p> | <p>Anthem will cover up to forty (40) inpatient days, or eighty (80) partial days (combined); excluding visits for management of medications.</p> <p>Anthem will cover up to forty (40) visits per calendar year for outpatient services; excluding visits for the management of medications.</p> |
| <p><b>Supplies, Equipment, and Appliances (DME)</b><br/>Inpatient/Outpatient<br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p>   | <p>50% coinsurance.</p>                         | <p>50% coinsurance.</p>                         | <p>Wigs are covered up to a maximum Anthem payment of \$500 per member per calendar year combined in and out-of-network, with a doctor's prescription. Footwear is limited to a \$400 maximum Anthem payment per calendar year, in- and out-of-network combined.</p>                              |
| <p><b>Home Health Care</b><br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p>   | <p>50% coinsurance.</p>                         | <p>50% coinsurance.</p>                         | <p>Benefits are limited to thirty (30) visits per member per calendar year, in- and out-of-network combined.</p>  |
| <p><b>Chemotherapy, Hemodialysis, and Radiation Therapy</b><br/>Inpatient/Outpatient<br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p>   | <p>50% coinsurance.</p>                         | <p>50% coinsurance.</p>                         |   |
| <p><b>Skilled Nursing Facility</b><br/>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br/>and \$7,500 plans:</p>   | <p>50% coinsurance.</p>                         | <p>50% coinsurance.</p>                         | <p>Benefits are limited to twenty (20) days per member per calendar year; in- and out-of-network combined</p>   |

| Services   | In-Network<br>after Deductible | Out-of-Network<br>after Deductible | Additional Information                                 |
|--|--------------------------------|------------------------------------|--|
| <b>Hospice Care</b><br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br>and \$7,500 plans:                                   | 50% coinsurance.               | 50% coinsurance.                   |  |
| <b>Human Organ and Tissue Transplant<br/>Services</b><br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br>and \$7,500 plans: | 50% coinsurance.               | 50% coinsurance.                   | See certificate for details on covered<br>transplants. |
| <b>Temporomandibular Joint<br/>Syndrome (TMJ)</b><br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br>and \$7,500 plans:     | 50% coinsurance.               | 50% coinsurance.                   |  |
| <b>Enteral Formula and Special Foods</b><br>For \$750, \$1,500, \$2,500, \$3,500, \$5,000<br>and \$7,500 plans:              | 50% coinsurance.               | 50% coinsurance.                   |  |

| Services                      | In-Network<br>after Deductible   | Out-of-Network<br>after Deductible | Additional Information |
|-------------------------------|--|------------------------------------|------------------------|
| Prescription Drugs            | <p>These benefits apply only to prescription drugs listed on Anthem's Plan Formulary. Members will pay 100% of the allowed amount for Drugs not shown on the Formulary.</p> <p><b>Participating Retail Pharmacy:</b></p> <ul style="list-style-type: none"> <li>• <b>Tier 1 Prescription Drugs:</b> \$15 copayment for each prescription and/or refill for a maximum thirty (30) day supply.</li> <li>• <b>Tier 2 Prescription Drugs:</b> After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, \$35 copayment for each prescription and/or refill for a maximum thirty (30) day supply.</li> <li>• <b>Tier 3 Prescription Drugs:</b> After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, 25% coinsurance, for each prescription and/or refill for a maximum thirty (30) day supply. <b>Tier 3 includes Specialty Prescription Drugs.*</b></li> </ul> <p><b>*Specialty Prescription Drugs</b> are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.</p> <p><b>Please see the section of the certificate entitled About Your Health Coverage for a full description of the Tier 2 and Tier 3 Prescription Drug Deductible and the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum.</b></p> <p><b>Tier 2 and Tier 3 Prescription drug Deductible</b><br/>Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of \$7,500 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical In-Network or Out-of-Network Provider Deductibles. This Tier 2 and Tier 3 Prescription Drug Deductible applies to Tier 2 and Tier 3 Prescription Drugs purchased at Participating Pharmacies and through the Mail Order Prescription Drug Program.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Copayments for the Tier 2 and Tier 3 deductible <b>will not</b> accumulate towards the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum and will continue to be required even after the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum has been reached.</li> <li>• The Tier 2 and Tier 3 Drug Deductible <b>will not</b> accumulate to satisfy the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum.</li> </ul> |                                    |                        |
| <b>DENTAL INJURY:</b>         | For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement. The first dental services must be performed within ninety (90) days after your accident and related services must be performed within one (1) year after your accident.  |                                    |                        |
| <b>DEPENDENT ELIGIBILITY:</b> | The end of the month in which the dependent child becomes age 26.  |                                    |                        |
| <b>PREAUTHORIZATION:</b>      | <p><b>Inpatient Services:</b><br/>Hospital (medical and surgical care) and Hospice Care services are subject to preauthorization.</p> <p><b>Outpatient Services:</b><br/>Outpatient surgeries in a Hospital are subject to preauthorization.</p>   |                                    |                        |

**Allowable Charge:** Reimbursement for covered services is based upon allowable charge as determined by Anthem Blue Cross and Blue Shield. Allowable charge means the contracted amount for participating providers or the maximum benefit allowance for non-participating providers. Anthem's determination of allowable charge is the maximum amount approved for any particular service. Deductible, coinsurance, or other cost sharing amounts are based on this allowance and are the amounts the member pays the provider.

**Anthem Blue Cross and Blue Shield Benefit Summary Disclosure Information**  
**Nevada Individual CoreShare PPO Plan**  
**Anthem Blue Cross and Blue Shield**  
**700 Broadway, Denver, CO 80273**  
**(888) 231-5046**

This disclosure statement provides only a brief description of some important features and limitations of your policy. The certificate itself sets forth in the detail the rights and obligations of both you and the insurance company. It is important that you review the certificate once you are enrolled.

**Coverage for treatment as part of a clinical trial:**

Includes coverage for medical treatment provided in a Phase I, Phase II, Phase III or Phase IV clinical trial for the treatment of cancer or in a Phase II, Phase III, or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome conducted in the state of Nevada.

Coverage for medical treatment is limited to:

- Any drug or device approved for sale by the Food and Drug Administration.
- The cost of any reasonably necessary health care services required from the medical treatment or complications thereof arising out of the medical treatment provided in the clinical trial.
- The initial consultation to determine whether the person is eligible to participate in a clinical trial.
- Health care services required for the clinically appropriate monitoring of the person during the clinical trial.

**Coverage for the management and treatment of diabetes**

Includes coverage for medication, equipment, supplies, and appliances that are medically necessary for the treatment of diabetes type I, type II, and gestational diabetes.

Coverage for self-management of diabetes, including:

- The training and education provided to a person covered under the contract after initial diagnosis of diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the program of self-management of diabetes.
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

**Medically Necessary**

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem, subject to a member's right to appeal, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member's family or the provider.
- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

**Allowable Charge** Reimbursement for benefits paid, except as provided below, is the allowable charge. The allowable charge is the dollar amount determined and approved by Anthem for covered services and procedures. Your applicable cost sharing requirements are based on the allowable charge.

For PPO and participating providers, the allowable charge is the contracted amount. PPO and participating providers have signed agreements to accept the contracted amount as payment in full. The contracts between Anthem and its providers include a “hold harmless” clause that provides that a member cannot be liable to the provider for moneys owed by Anthem for health care services covered under this certificate.

For non-participating providers, the allowable charge is the maximum benefit allowance. The member must pay any difference between Anthem’s maximum benefit allowance and the non-participating provider’s charge, except as provided below.

**NOTE:** Anthem will reimburse covered services received from a non-participating provider on the basis of billed charges rather than the maximum benefit allowance in the following circumstances:

- Emergency care (when rendered either within or outside the State of Nevada)
- Where inpatient hospital care at a non-participating provider is necessary due to the nature of treatment
- Where inpatient hospital care at a non-participating provider is necessary due to participating provider hospital capacity

In all other situations the maximum benefit allowance does apply.

**“Emergency medical condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**“Emergency services”** means, with respect to an emergency medical condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term **“stabilize”** means, with respect to an emergency medical condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

### **Maximum Benefits**

Some services or supplies may have an annual maximum benefit. Be sure to review your summary of benefits for further details on what services may have a maximum benefit.

### **Limitations and Exclusions**

This plan does not cover some services. The plan includes limitations and exclusions to protect against duplicate or unnecessary services that could unfairly offset the cost of health care coverage for the entire plan. Please note the following examples of some of the plan’s limitations and exclusions:

- Alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, message therapy, acupuncture, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization (BEST), colonics or iridology.
- Artificial conception.
- Services received before the effective date of coverage.
- Biofeedback.
- Blood, blood plasma and blood derivatives replaced through donor credit.
- Chelating agents, except for providing treatment for heavy metal poisoning.
- Services or supplies provided as part of clinical research, except where required by law or allowed by Anthem.
- Complications from non-covered services.
- Convalescent care.
- Convenience, luxury, deluxe services or equipment. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass

frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).

- Cosmetic services.
- Court ordered services unless those services are otherwise covered under the certificate.
- Custodial care.
- Dental services except for accident related dental services, dental anesthesia for children, temporomandibular joint therapy or surgery.
- Inpatient care received after the date Anthem, using managed care guidelines, determines discharge is appropriate.
- Domiciliary care such as care provided in a residential, non-treatment institution, halfway house or school.
- Experimental/Investigative procedures.
- Genetic testing or counseling.
- Government operated facility such as a military medical facility or veterans administration facility, unless authorized by Anthem.
- Hearing aids or routine hearing tests.
- Hypnosis, whether for medical or anesthesia purposes.
- This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation.
- Services or supplies for the treatment of intractable pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.
- Therapies for learning deficiencies and/or behavioral problems.
- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to a keep scheduled appointment.
- Neuropsychiatric testing.
- Non-covered providers who include, but are not limited to:
  - Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
  - School infirmary.
  - Halfway house.
  - Massage therapist.
  - Nursing home.
  - Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Non-medical expenses, including but not limited to:
  - Adoption expenses.
  - Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
  - Vocational training services and supplies.
  - Mailing and/or shipping and handling expenses.
  - Interest expenses and delinquent payment fees.
  - Modifications to home, vehicle, or workplace regardless of medical condition or disability.
  - Health club memberships: This coverage does not cover health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.
  - Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
  - Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
  - Voice synthesizers or other communication devices, except as specifically allowed by Anthem's medical policy.
- Nutritional and/or dietary supplements: This coverage does not cover nutritional and/or dietary supplements, except as provided in the certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
- Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital imperfection or acquired characteristic.
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use. These include but are not limited to, home pregnancy tests and home HIV tests.
- Benefits are not provided for care received after coverage is terminated.



- Pre-existing conditions — For members age 19 and older, expenses resulting from pre-existing conditions are not paid until the coverage has been in effect for 12 consecutive months.
- Condition waivers — For members age 19 and older, this plan does not provide coverage for any condition for which benefits are excluded by a Waiver.
- Services related to pregnancy including prenatal and deliver services.
- Surrogate mother services: This coverage does not cover any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- Private duty nursing services.
- Private rooms are not covered.
- Charges for services and supplies when the member has received a professional or courtesy discount from a provider or where the member's portion of the payment is waived due to professional courtesy or discount.
- Ultrafast CT scan and peripheral bone density testing. This coverage does not cover the following except as described by medical policy screening or as provided in the certificate, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.
- Charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.
- Services or supplies necessitated by injuries which a member intentionally self inflicted, except where the law prohibits such an exclusion
- Reversal of sterilization: This coverage does not cover services to reverse voluntarily induced sterility.
- Services or supplies related to sex-change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation.
- Treatment of sexual dysfunction or impotence including all services, supplies, or prescription drugs used for treatment.
- Smoking cessation programs, products, drugs or medications, hypnosis, supplies or devices to quit smoking.
- Travel or lodging expenses for the member, member's family or the physician except as travel or lodging expenses related to human organ and tissue transplants.
- Routine eye examinations, routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which requires the the use of contact lenses), or prescriptions for such services and supplies. Surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.
- Weight loss programs: This coverage does not cover weight loss programs whether or not they are pursued under medical or physician supervision. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- Services and supplies for a work-related accident or illness.
- Non-Severe Mental Health services, except for the treatment of Severe Mental Health Conditions.
- Surgery for treatment of morbid obesity.
- Immunizations for travel.
- Physical rehabilitation is limited to twenty four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined.
- Benefits are paid up to thirty six (36) visits for cardiac rehabilitation. The program must start within three months of a major cardiac event and be completed within six months of the major cardiac event.
- Benefits for speech therapy are paid up to twenty (20) visits per calendar year; in- and out-of-network combined.
- Severe Mental Illness limits are:
  - Anthem will cover up to forty (40) inpatient days, or eighty (80) partial days (combined); excluding visits for management of medications.
  - Anthem will cover up to forty (40) visits per calendar year for outpatient services; excluding visits for management of medications.
- Supplies, Equipment, and Appliances (DME) limits are:
  - Wigs are covered up to a maximum Anthem payment of \$500 per member per calendar year; in and out-of-network combined, with a doctor's prescription.
  - Footwear is limited to a \$400 maximum Anthem payment per calendar year; in- and out-of-network combined.
- Home health care benefits are limited to thirty (30) visits per member per calendar year, in and out-of-network providers combined.
- Skilled nursing facility services benefits are limited to twenty (20) days per member per calendar year; in- and out-of-network combined.

**Rate determinations**

Individual policies:

- Rates are based on age, gender, benefit plan, family size, geographic location and tobacco use.
- For families with more than three children, the family rate is capped at three children.
- When a member or spouse attains an age that requires a rate change to a new category, the adjustment will be made on the policy anniversary date and the premium will be automatically adjusted to the new rate.
- Rates are subject to change with 60-day written notice.

**Policy Renewal Provisions**

**Individual policies — This coverage is renewable at your option, except for the following reasons:**

- Non-payment of the required premium;
- When the member has committed any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that may result in termination or rescission of that member’s coverage;
- The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier’s ability to meet its contractual obligations;
- The carrier elects to discontinue offering and non-renew all of its individual, small group or large group plans delivered or issued for delivery in Nevada.

**Provider Directories**

Copies of provider directories for all products offered by Anthem may be obtained by calling the customer service department or accessing the information on our Internet site at [www.Anthem.com](http://www.Anthem.com).

**Provider Network**

Under Anthem PPO plans, members choose physicians, hospitals and other health care providers from the Anthem preferred provider organization (PPO) network. Using the PPO network can mean substantial savings. If care is received outside the PPO network, the member will pay a higher deductible, coinsurance and charges over the Allowable Charge.

**Broker Name, Address and Telephone Number (If applicable):**

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# Nevada Individual ClearProtection PPO 1,000, 3,300, 5,000 Summary of Benefits



This summary provides you with the deductible, coinsurance, and a brief description of your benefits. For more complete information, see your certificate or call Anthem's customer service department toll free at (888) 231-5046. **Coinsurance options reflect the percentage of the allowable charge that the covered person will pay.**

|  | In-Network  |   | Out-of-Network  |   |
|--|---|---|---|---|
| <b>Out-of-Pocket Annual Maximum</b><br>The Out-of-Pocket Annual Maximum includes the deductible but is not combined for in- and out-of-network | <b>Individual:</b><br>\$4,500, \$6,800, \$8,500   | <b>Family:</b><br>\$9,000, \$13,600, \$17,000 | <b>Individual:</b><br>\$4,500, \$6,800, \$8,500   | <b>Family:</b><br>\$9,000, \$13,600, \$17,000 |
|  | Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Services Deductible amount or Copayment/Coinsurance amounts, except as otherwise required by this policy for the remainder of that year. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum. |   | Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Services Deductible amount or Copayment/Coinsurance amounts, except as otherwise required by this policy for the remainder of that year, <b>except</b> for charges in excess of the Maximum Benefit Allowance and where specifically noted in the certificate. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum.<br><br>A member will always be responsible for the difference between billed charges and the maximum benefit allowance for non-participating providers, even after reaching the Out-of-Pocket Annual Maximum for Out-of-Network services. Charges in excess of the maximum benefit allowance do not count towards satisfying the Out-of-Pocket Annual Maximum. |   |
| Copayment amounts do not apply to the Out-of-Pocket Annual Maximum.  |   |   |   |   |

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|   | In-Network   | Out-of-Network  |
|---|--|---|
| <p><b>Inpatient Surgical/Hospital Deductible</b><br/>(Not combined for In-Network and Out-of-Network)</p> <p>Applicable only to the following services:</p> <ul style="list-style-type: none"> <li>• All inpatient services</li> <li>• Ambulatory Surgery Center Services</li> <li>• Emergency Room Visits</li> <li>• Home Health Care</li> <li>• Skilled Nursing Care</li> <li>• Hospice Services</li> <li>• Ambulance Services</li> </ul> | <p><b>Individual:</b><br/>\$1,000, \$3,300, \$5,000</p> <p>During each Year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital Deductible amount. Once you have satisfied your Surgical/Hospital Deductible, no further Surgical/Hospital Deductible will be required for the remainder of that Year.</p> <p><b>Family Maximum:</b><br/>\$2,000, \$6,600, \$10,000</p> <p>During each year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital deductible amount. Once you have satisfied your In-Network Surgical/Hospital deductible, no further Surgical/Hospital deductible will be required for the remainder of that year.</p> <p>Once the total of allowable charges applying to the Surgical/Hospital Deductible for two (2) or more members equal the Surgical/Hospital Deductible Family Maximum, no further Surgical/Hospital Deductible will be required for all enrolled members for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family deductible amount.</p> | <p><b>Individual:</b><br/>\$1,000, \$3,300, \$5,000</p> <p>During each Year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital Deductible amount. Once you have satisfied your Surgical/Hospital Deductible, no further Surgical/Hospital Deductible will be required for the remainder of that Year.</p> <p><b>Family Maximum:</b><br/>\$2,000, \$6,600, \$10,000</p> <p>During each year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital deductible amount. Once you have satisfied your Out-of-Network Surgical/Hospital deductible, no further Surgical/Hospital deductible will be required for the remainder of that year.</p> <p>Once the total of allowable charges applying to the Surgical/Hospital Deductible for two (2) or more members equal the Surgical/Hospital Deductible Family Maximum, no further Surgical/Hospital Deductible will be required for all enrolled members for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family deductible amount.</p> <p>For Non-Participating providers, the member must pay the difference between Anthem's maximum benefit allowance and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum benefit allowance do not count towards satisfying the Inpatient Surgical/Medical Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.</p> |
| Copayment amounts do not apply to the deductible.   |  |   |

| Services subject to the Inpatient Surgical/Hospital Deductible         | In-Network after Deductible                                       | Out-of-Network after Deductible  | Additional Information |
|--|---|--|------------------------|
| <b>Inpatient Hospital Care</b>   | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance. |                        |
| <b>Outpatient Hospital Surgical Services/Ambulatory Surgery Center</b> | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance. |                        |

| <b>Services subject to the Inpatient Surgical/Hospital Deductible</b> | <b>In-Network after Deductible</b>  | <b>Out-of-Network after Deductible</b>  | <b>Additional Information</b>   |
|---|---|---|---|
| <b>Emergency Care</b>   | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance<br><br>Emergency Room services are subject to an additional \$100 Copayment per visit which will not be applied towards the Inpatient Surgical/Hospital Deductible or Out-of-Pocket Annual Maximum. | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance<br><br>Emergency Room services are subject to an additional \$100 Copayment per visit which will not be applied towards the Inpatient Surgical/Hospital Deductible or Out-of-Pocket Annual Maximum. | The \$100 emergency room copayment is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.<br><br>Copayment amounts do not apply to the deductible or the out of pocket maximum.  |
| <b>Home Health Care</b>   | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance.  | Benefits are limited to sixty (60) visits per member per calendar year combined in and out-of-network.  |
| <b>Skilled Nursing Facility</b>                                       | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance.  | Benefits are limited to twenty (20) days per member per calendar year; in- and out-of-network combined  |
| <b>Alcohol and Drug Abuse (Inpatient Services)</b>                    | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance.  |   |
| <b>Severe Mental Illness (Inpatient Services)</b>                     | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance.  | Severe mental illness conditions are: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder.<br><br>Benefits are paid up to 40 inpatient days, or 80 partial days (combined) excluding visits for management of medications. |
| <b>Hospice Care</b>   | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance.  |   |
| <b>Human Organ and Tissue Transplant Services</b>                     | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 50% coinsurance plus all charges in excess of the maximum benefit allowance.  | See certificate for details on covered transplants.   |
| <b>Ambulance Services</b><br>Ground Services/Air Services             | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance   | After the Inpatient Surgical/Hospital Deductible, 30% coinsurance plus all charges in excess of the maximum benefit allowance.  | Benefits are paid for medically necessary ground or air ambulance transportation.   |

|   | <b>In-Network</b>  | <b>Out-of-Network</b>   |
|---|--|---|
| <p><b>Outpatient Professional Services Deductible</b><br/>(Not combined for In-Network and Out-of-Network)</p> <p>Applicable only to the following services:</p> <ul style="list-style-type: none"> <li>• Professional Services<br/><b>Note:</b> The first two (2) office visits from In-Network Providers are covered at a \$40 copay per member, per calendar year regardless of the type of provider seen. The Outpatient Professional Services Deductible is waived, but the \$40 office visit copayment will not be applied towards the In-network Out-of-Pocket Annual maximum.</li> <li>• Physical, Occupational and Speech Therapy</li> </ul> | <p><b>Individual:</b><br/>\$4,500, \$6,800, \$8,500</p> <p>During each Year, each member is responsible for all Outpatient Professional expenses incurred up to the Outpatient Professional Services Deductible amount. Once you have satisfied your In Network and/or Out-of-Network Provider Outpatient Professional Services Deductible, no further Outpatient Professional Services Deductible will be required for the remainder of that Year.</p> <p><b>Family Maximum:</b><br/>\$9,000, \$13,600, \$17,000</p> <p>Once the total of allowable charges applying to the Outpatient Professional Services Deductible for two (2) or more members equal the Outpatient Professional Services Deductible Family Maximum, no further Outpatient Professional Services Deductible will be required for all enrolled members for the remainder of that Year. No one member can contribute more than the individual deductible amount to the family deductible amount.</p> | <p><b>Individual:</b><br/>\$4,500, \$6,800, \$8,500</p> <p>During each Year, each member is responsible for all Outpatient Professional expenses incurred up to the Outpatient Professional Services Deductible amount. Once you have satisfied your In Network and/or Out-of-Network Provider Outpatient Professional Services Deductible, no further Outpatient Professional Services Deductible will be required for the remainder of that Year.</p> <p><b>Family Maximum:</b><br/>\$9,000, \$13,600, \$17,000</p> <p>Once the total of allowable charges applying to the Outpatient Professional Services Deductible for two (2) or more members equal the Outpatient Professional Services Deductible Family Maximum, no further Outpatient Professional Services Deductible will be required for all enrolled members for the remainder of that Year. No one member can contribute more than the individual deductible amount to the family deductible amount.</p> <p>For Non-Participating providers, the member must pay the difference between Anthem's maximum benefit allowance and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum benefit allowance do not count towards satisfying the Outpatient Professional Services Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.</p> |
| Copayment amounts do not apply to the deductible  |  |   |

| Services  | In-Network after Deductible  | Out-of-Network after Deductible   | Additional Information  |
|---|--|---|---|
| <p><b>Physician Visits</b><br/>Inpatient/Outpatient</p> <p>Office Visit</p> | <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance</p> <p>\$40 copayment per office visit for the first two (2) office visits in a calendar year.</p> <p>After the first two (2) office visits in a calendar year have been used, the member pays 100% of the allowed amount until the Outpatient Professional Services Deductible has been satisfied, then 0% coinsurance.</p> | <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance.</p> <p>For physician office visits, member pays 100% coinsurance plus all charges in excess of the maximum benefit allowance. Once the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum benefit allowance.</p> | <p>The first two (2) office visits from In-Network Providers are covered at a copay of \$40 per member, per calendar year regardless of the type of provider seen. The total number of visits covered at the \$40 copay is combined for all In-Network Providers. No Outpatient Professional Services Deductible is required for the first two (2) office visits from In-Network Providers.</p> <p>Services covered as part of an office visit include:</p> <ul style="list-style-type: none"> <li>• History (gathering of information on an illness or injury)</li> <li>• Examination</li> <li>• Medical decision making (the physician's actual diagnosis and treatment plan)</li> </ul> <p>All other covered professional services, including, but not limited to laboratory, X-ray, radiology and pathology services are subject to applicable deductible, coinsurance, or cost sharing. Please see the Professional Services section of the certificate for a full description of covered professional services.</p> <p>After the first two (2) In-Network physician office visits have been used, charges for additional physician office visits will be subject to the Outpatient Professional Services Deductible and Out-of-Pocket Annual Maximum.</p> <p>Copayment amounts do not apply to the deductible or the out of pocket maximum.</p> |

| Services  | In-Network after Deductible   | Out-of-Network after Deductible   | Additional Information  |
|---|---|---|---|
| <p><b>Preventive Care Services</b></p> <p>Preventive Care Services in this section shall meet requirements as determined by federal and state law. These services fall under four broad categories as shown below:</p> <ol style="list-style-type: none"> <li>1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for: <ul style="list-style-type: none"> <li>• Breast cancer;</li> <li>• Cervical cancer;</li> <li>• Colorectal cancer;</li> <li>• High Blood Pressure;</li> <li>• Type 2 Diabetes Mellitus;</li> <li>• Cholesterol;</li> <li>• Child and Adult Obesity.</li> </ul> </li> <li>2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;</li> <li>3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and</li> <li>4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.</li> </ol> | <p>Many In-Network preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member. That means Anthem pays 100% of the Allowable Charge.</p> | <p>Physician office visits and other professional services are subject to the Outpatient Professional Services Deductible.</p> <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum benefit allowance.</p> | <p>Professional services are services provided during a physician office-based visit, include, but are not limited to laboratory, X-ray, radiology and pathology services.</p> <p>Please see the Preventive Care Services section of the certificate for a full description of covered preventive care services.</p> <p>Copayment amounts do not apply to the deductible or the out of pocket annual maximum.</p> |
| <p><b>Diagnostic Services, Laboratory, Pathology, and X-ray</b></p>   | <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance</p>   | <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance.</p>  | <p>Services billed by a hospital are included in the hospital inpatient/outpatient surgical benefits.</p>   |
| <p><b>Maternity Care</b></p>  | <p>Not covered</p>  | <p>Not covered</p>  | <p>Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.</p>  |
| <p><b>Physical Rehabilitation</b><br/>(Physical therapy, occupational therapy, cardiac rehabilitation)</p>  | <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance</p>   | <p>After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance.</p>  | <p>Physical rehabilitation is limited to twenty four (24) visits per calendar year for physical therapy, occupational therapy; in- and out-of-network combined.</p>   |



| <b>Services</b>  | <b>In-Network<br/>after Deductible</b>   | <b>Out-of-Network<br/>after Deductible</b>  | <b>Additional Information</b>  |
|--|--|---|--|
| <b>Speech Therapy</b>                                    | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. | Benefits are paid up to twenty (20) visits per calendar year; in- and out-of-network combined.   |
| <b>Spinal Manipulations</b>                              | Not covered  | Not covered   |  |
| <b>Acupuncture</b>                                       | Not covered  | Not covered   |  |
| <b>Supplies, Equipment, and Appliances (DME)</b>         | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. | Wigs are covered up to a maximum Anthem payment of \$500 per member per calendar year combined in and out-of-network, with a doctor's prescription.<br><br>Footwear is limited to a \$400 maximum Anthem payment per calendar year, in- and out-of-network combined.                         |
| <b>Chemotherapy, Hemodialysis, and Radiation Therapy</b> | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. |  |
| <b>Temporomandibular Joint Syndrome (TMJ)</b>            | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. |  |
| <b>Enteral Formula and Special Foods</b>                 | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. |  |
| <b>Alcohol and Drug Abuse</b>                            | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. |  |
| <b>Severe Mental Illness (Outpatient Services)</b>       | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance | After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance, but the member pays all charges in excess of the maximum benefit allowance. | Severe mental illness conditions are: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder.<br><br>Benefits are paid up to 40 visits per calendar year excluding visits for the management of medications. |

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| <p><b>Prescription Drugs</b></p> | <p><b>These benefits apply only to prescription drugs listed on Anthem’s Plan Formulary. Members will pay 100% of the allowed amount for Drugs not shown on the Formulary.</b></p> <p><b>Participating Retail Pharmacy:</b></p> <ul style="list-style-type: none"> <li>• <b>Tier 1 Prescription Drugs:</b> \$15 copayment for each prescription and/or refill for a maximum thirty (30) day supply.</li> <li>• <b>Tier 2 Prescription Drugs:</b> After the \$7,500 Tier 2 and Tier3 Prescription Drug Deductible has been satisfied, \$35 copayment for each prescription and/or refill for a maximum thirty (30) day supply.</li> <li>• <b>Tier 3 Prescription Drugs:</b> After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, 25% coinsurance, for each prescription and/or refill for a maximum thirty (30) day supply. <b>Tier 3 includes Specialty Prescription Drugs.*</b></li> </ul> <p><b>*Specialty Prescription Drugs</b> are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.</p> <p><b>Please see the section of the certificate entitled About Your Health Coverage for a full description of the Tier 2 and Tier 3 Prescription Drug Deductible and the Tier 3 Prescription Drug Out-of-Pocket Maximum.</b></p> <p><b>Tier 2 and Tier 3 Prescription drug Deductible</b><br/> Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of \$7,500 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical In-Network or Out-of-Network Provider Deductibles. This Tier 2 and Tier 3 Prescription Drug Deductible applies to Tier 2 and Tier 3 Prescription Drugs purchased at Participating Pharmacies and through the Mail Order Prescription Drug Program.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Copayments for the Tier 2 and Tier 3 deductible <b>will not</b> accumulate towards the Tier 3 Prescription Drug Out-of-Pocket Maximum and will continue to be required even after the Tier 3 Prescription Drug Out-of-Pocket Maximum has been reached.</li> <li>• The Tier 2 and Tier 3 Drug Deductible <b>will not</b> accumulate to satisfy the Tier 3 Prescription Drug Out-of-Pocket Maximum.</li> </ul> <p><b>Tier 3 Prescription Drug Out-of-Pocket Maximum:</b><br/> There is a \$2,500 Tier 3 Out-of-Pocket Maximum for prescription drugs per member per calendar year when purchased from participating pharmacies (retail, mail order, and preferred specialty pharmacies). Members will not be required to pay more than \$2,500 per calendar year for prescription drugs purchased from participating pharmacies (retail, mail order, and preferred specialty pharmacies). Once the \$2,500 Tier 3 Out-of-Pocket Maximum is met, no further copayments or coinsurance will be required for Tier 3 covered prescriptions obtained from participating pharmacies (retail, mail order, and preferred specialty pharmacies), for the remainder of that calendar year.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Copayments for Tier 1 and Tier 2 drugs <b>will not</b> accumulate towards the Tier 3 Prescription Drug Coinsurance Maximum, and will continue to be required even after the Tier 3 Prescription Drug Coinsurance Maximum has been reached.</li> <li>• The Tier 2 and 3 Prescription Drug Deductible does not accumulate to satisfy the Tier 3 Prescription Drug Out-of-Pocket Maximum.</li> <li>• The Tier 3 Prescription Drug Out-of-Pocket Maximum does not accumulate towards satisfying the medical In-Network and Out-of-Network Medical Out-of-Pocket Annual Maximum.</li> </ul> <p><b>Mail Order:</b></p> <ul style="list-style-type: none"> <li>• <b>Tier 1 Prescription Drugs:</b> \$45.00 copayment for each prescription and/or refill for each ninety (90) day supply.</li> <li>• <b>Tier 2 Prescription Drugs:</b> After a \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, \$105.00 copayment for each prescription and/or refill for each ninety (90) day supply.</li> <li>• <b>Tier 3 Prescription Drugs:</b> After a \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible is satisfied, 25% coinsurance for each prescription and/or refill for each ninety (90) day supply until the \$2,500 Tier 3 Prescription Drug Out-of-Pocket Maximum is satisfied. <b>Note:</b> Specialty Drugs are limited to a thirty (30) day supply.</li> </ul> |
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| <p><b>Prescription Drugs</b><br/>(continued)</p> | <p><b>Out-of-Network (Retail or Mail-Order) Pharmacy:</b><br/>Please see the Member Benefits section in your Certificate for information on how to file a claim from an out-of-network pharmacy.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 Prescription Drugs:</b> <ul style="list-style-type: none"> <li>◦ \$15 copayment, <b>plus</b> the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill for a maximum thirty (30) day supply retail.</li> <li>◦ \$45.00 copayment <b>plus</b> the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill for each ninety (90) day supply mail order.</li> </ul> </li> <li>• <b>Tier 2 Prescription Drugs:</b> <ul style="list-style-type: none"> <li>◦ After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, \$35 copayment, <b>plus</b> the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill for a maximum thirty (30) day supply retail.</li> <li>◦ After a \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, \$105.00 copayment <b>plus</b> the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill for each ninety (90) day supply mail order.</li> </ul> </li> <li>• <b>Tier 3 Prescription Drugs:</b> <ul style="list-style-type: none"> <li>◦ After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, 25% coinsurance, <b>plus</b> the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill for a maximum thirty (30) day supply retail until the \$2,500 Tier 3 Prescription Drug Out-of-Pocket Maximum is satisfied.</li> <li>◦ After a \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible is satisfied, 25% coinsurance <b>plus</b> the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill for each ninety (90) day supply mail order until the \$2,500 Tier 3 Prescription Drug Out-of-Pocket Maximum is satisfied. <b>Note:</b> Specialty Drugs are limited to a thirty (30) day supply.</li> </ul> </li> </ul> <p><b>Non-Formulary Prescription Drugs:</b><br/>Charges for non-formulary prescription drugs will not be applied towards the Tier 2 and 3 Prescription Drug Deductible or the Tier 3 Out-of-Pocket Maximum.</p> <ul style="list-style-type: none"> <li>• Member pays 100% of the contracted amount if purchased from a participating pharmacy.</li> <li>• Member pays 100% of the cash price if purchased from a non-participating pharmacy.</li> </ul> <p>Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency Care.</p> |
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| <p><b>DENTAL INJURY:</b></p>         | <p>For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement. The first dental services must be performed within ninety (90) days after your accident and related services must be performed within one (1) year after your accident.</p> |
| <p><b>DEPENDENT ELIGIBILITY:</b></p> | <p>The end of the month in which the dependent child becomes age 26.</p>   |
| <p><b>PREAUTHORIZATION:</b></p>      | <p><b>Inpatient Services:</b><br/>Hospital (medical and surgical care) and Hospice Care services are subject to preauthorization.</p> <p><b>Outpatient Services:</b><br/>Outpatient surgeries in a Hospital are subject to preauthorization.</p>   |

**Allowable Charge:** Reimbursement for covered services is based upon allowable charge as determined by Anthem Blue Cross and Blue Shield. Allowable charge means the contracted amount for participating providers or the maximum benefit allowance for non-participating providers. Anthem's determination of allowable charge is the maximum amount approved for any particular service. Deductible, coinsurance, or other cost sharing amounts are based on this allowance and are the amounts the member pays the provider.

**Anthem Blue Cross and Blue Shield Benefit Summary Disclosure Information**  
**Nevada Individual ClearProtection PPO Plan**  
**Anthem Blue Cross and Blue Shield**  
**700 Broadway, Denver, CO 80273**  
**(888) 231-5046**

This disclosure statement provides only a brief description of some important features and limitations of your policy. The certificate itself sets forth in the detail the rights and obligations of both you and the insurance company. It is important that you review the certificate once you are enrolled.

**Coverage for treatment as part of a clinical trial:**

Includes coverage for medical treatment provided in a Phase I, Phase II, Phase III or Phase IV clinical trial for the treatment of cancer or in a Phase II, Phase III, or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome conducted in the state of Nevada.

Coverage for medical treatment is limited to:

- Any drug or device approved for sale by the Food and Drug Administration.
- The cost of any reasonably necessary health care services required from the medical treatment or complications thereof arising out of the medical treatment provided in the clinical trial.
- The initial consultation to determine whether the person is eligible to participate in a clinical trial.
- Health care services required for the clinically appropriate monitoring of the person during the clinical trial.

**Coverage for the management and treatment of diabetes**

Includes coverage for medication, equipment, supplies, and appliances that are medically necessary for the treatment of diabetes type I, type II, and gestational diabetes.

Coverage for self-management of diabetes, including:

- The training and education provided to a person covered under the contract after initial diagnosis of diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the program of self-management of diabetes.
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

**Medically Necessary**

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem, subject to a member's right to appeal, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member's family or the provider.
- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

**Allowable Charge** Reimbursement for benefits paid, except as provided below, is the allowable charge. The allowable charge is the dollar amount determined and approved by Anthem for covered services and procedures. Your applicable cost sharing requirements are based on the allowable charge.

For PPO and participating providers, the allowable charge is the contracted amount. PPO and participating providers have signed agreements to accept the contracted amount as payment in full. The contracts between Anthem and its providers include a “hold harmless” clause that provides that a member cannot be liable to the provider for moneys owed by Anthem for health care services covered under this certificate.

For non-participating providers, the allowable charge is the maximum benefit allowance. The member must pay any difference between Anthem’s maximum benefit allowance and the non-participating provider’s charge, except as provided below.

**NOTE:** Anthem will reimburse covered services received from a non-participating provider on the basis of billed charges rather than the maximum benefit allowance in the following circumstances:

- Emergency care (when rendered either within or outside the State of Nevada)
- Where inpatient hospital care at a non-participating provider is necessary due to the nature of treatment
- Where inpatient hospital care at a non-participating provider is necessary due to participating provider hospital capacity

In all other situations the maximum benefit allowance does apply.

**“Emergency medical condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**“Emergency services”** means, with respect to an emergency medical condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term **“stabilize”** means, with respect to an emergency medical condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

### **Maximum Benefits**

Some services or supplies may have an annual maximum benefit. Be sure to review your summary of benefits for further details on what services may have a maximum benefit.

### **Limitations and Exclusions**

This plan does not cover some services. The plan includes limitations and exclusions to protect against duplicate or unnecessary services that could unfairly offset the cost of health care coverage for the entire plan. Please note the following examples of some of the plan’s limitations and exclusions:

- Alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, message therapy, acupuncture, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization (BEST), colonics or iridology.
- Artificial conception.
- Services received before the effective date of coverage.
- Biofeedback.
- Blood, blood plasma and blood derivatives replaced through donor credit.
- Chelating agents, except for providing treatment for heavy metal poisoning.
- Services or supplies provided as part of clinical research, except where required by law or allowed by Anthem.
- Complications from non-covered services.
- Convalescent care.
- Convenience, luxury, deluxe services or equipment. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass

frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).

- Cosmetic services.
- Court ordered services unless those services are otherwise covered under the certificate.
- Custodial care.
- Dental services except for accident related dental services, dental anesthesia for children, temporomandibular joint therapy or surgery.
- Inpatient care received after the date Anthem, using managed care guidelines, determines discharge is appropriate.
- Domiciliary care such as care provided in a residential, non-treatment institution, halfway house or school.
- Experimental/Investigative procedures.
- Genetic testing or counseling.
- Government operated facility such as a military medical facility or veterans administration facility, unless authorized by Anthem.
- Hearing aids or routine hearing tests.
- Hypnosis, whether for medical or anesthesia purposes.
- This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation.
- Services or supplies for the treatment of intractable pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

Therapies for learning deficiencies and/or behavioral problems.

- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to a keep scheduled appointment.
- Neuropsychiatric testing.
- Non-covered providers who include, but are not limited to:
  - Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
  - School infirmary.
  - Halfway house.
  - Massage therapist.
  - Nursing home.
  - Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Non-medical expenses, including but not limited to:
  - Adoption expenses.
  - Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
  - Vocational training services and supplies.
  - Mailing and/or shipping and handling expenses.
  - Interest expenses and delinquent payment fees.
  - Modifications to home, vehicle, or workplace regardless of medical condition or disability.
  - Health club memberships: This coverage does not cover health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.
  - Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
  - Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
  - Voice synthesizers or other communication devices, except as specifically allowed by Anthem's medical policy.
- Nutritional and/or dietary supplements: This coverage does not cover nutritional and/or dietary supplements, except as provided in the certificate or as required by law. This exclusion includes, but is not limited to , those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
- Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital imperfection or acquired characteristic.
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use. These include but are not limited to, home pregnancy tests and home HIV tests.

- Benefits are not provided for care received after coverage is terminated.
- Pre-existing conditions — For members age 19 and older, expenses resulting from pre-existing conditions are not paid until the coverage has been in effect for 12 consecutive months.
- Condition waivers — For members age 19 and older, this plan does not provide coverage for any condition for which benefits are excluded by a Waiver.
- Services related to normal pregnancy including prenatal and deliver services.
- Surrogate mother services: This coverage does not cover any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- Private duty nursing services.
- Private rooms are not covered.
- Charges for services and supplies when the member has received a professional or courtesy discount from a provider or where the member's portion of the payment is waived due to professional courtesy or discount.
- Ultrafast CT scan and peripheral bone density testing. This coverage does not cover the following except as described by medical policy screening or as provided in the certificate, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.
- Charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.
- Services or supplies necessitated by injuries which a member intentionally self inflicted, except where the law prohibits such an exclusion
- Reversal of sterilization: This coverage does not cover services to reverse voluntarily induced sterility.
- Services or supplies related to sex-change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation.
- Treatment of sexual dysfunction or impotence including all services, supplies, or prescription drugs used for treatment.
- Smoking cessation programs, products, drugs or medications, hypnosis, supplies or devices to quit smoking.
- Travel or lodging expenses for the member, member's family or the physician except as travel or lodging expenses related to human organ and tissue transplants.
- Routine eye examinations, routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which requires the use of contact lenses), or prescriptions for such services and supplies. Surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.
- Weight loss programs: This coverage does not cover weight loss programs whether or not they are pursued under medical or physician supervision. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- Services and supplies for a work-related accident or illness.
- Non-Severe Mental Health services, except for the treatment of Severe Mental Health Conditions.
- Surgery for treatment of morbid obesity.
- Immunizations for travel.
- Physical rehabilitation is limited to twenty four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined.
- Benefits are paid up to thirty six (36) visits for cardiac rehabilitation. The program must start within three months of a major cardiac event and be completed within six months of the major cardiac event.
- Benefits for speech therapy are paid up to twenty (20) visits per calendar year; in- and out-of-network combined.
- Severe Mental Illness limits are:
  - Anthem will cover up to forty (40) inpatient days, or eighty (80) partial days (combined); excluding medication management.
  - Anthem will cover up to forty (40) visits per calendar year for outpatient services; excluding medication management.
- Supplies, Equipment, and Appliances (DME) limits are:
  - Wigs are covered up to a maximum Anthem payment of \$500 per member per calendar year; in and out-of-network combined, with a doctor's prescription.
  - Footwear is limited to a \$400 maximum Anthem payment per calendar year; in- and out-of-network combined.
- Home health care benefits are limited to sixty (60) visits per member per calendar year, in and out-of-network providers combined.
- Skilled nursing facility services benefits are limited to twenty (20) days per member per calendar year; in- and out-of-network combined.

**Rate determinations**

Individual policies:

- Rates are based on age, gender, benefit plan, family size, geographic location and tobacco use.
- For families with more than three children, the family rate is capped at three children.
- When a member or spouse attains an age that requires a rate change to a new category, the adjustment will be made on the policy anniversary date and the premium will be automatically adjusted to the new rate.
- Rates are subject to change with 60-day written notice.

**Policy Renewal Provisions**

**Individual policies — This coverage is renewable at your option, except for the following reasons:**

- Non-payment of the required premium;
- When the member has committed any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that may result in termination or rescission of that member’s coverage.
- The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier’s ability to meet its contractual obligations;
- The carrier elects to discontinue offering and non-renew all of its individual, small group or large group plans delivered or issued for delivery in Nevada.

**Provider Directories**

Copies of provider directories for all products offered by Anthem may be obtained by calling the customer service department or accessing the information on our Internet site at [www.Anthem.com](http://www.Anthem.com).

**Provider Network**

Under Anthem PPO plans, member’s choose physicians, hospitals and other health care providers from the Anthem preferred provider organization (PPO) network. Using the PPO network can mean substantial savings. If care is received outside the PPO network, the member will pay a higher deductible, coinsurance and charges over the Allowable Charge.

**Broker Name, Address and Telephone Number (If applicable):**

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