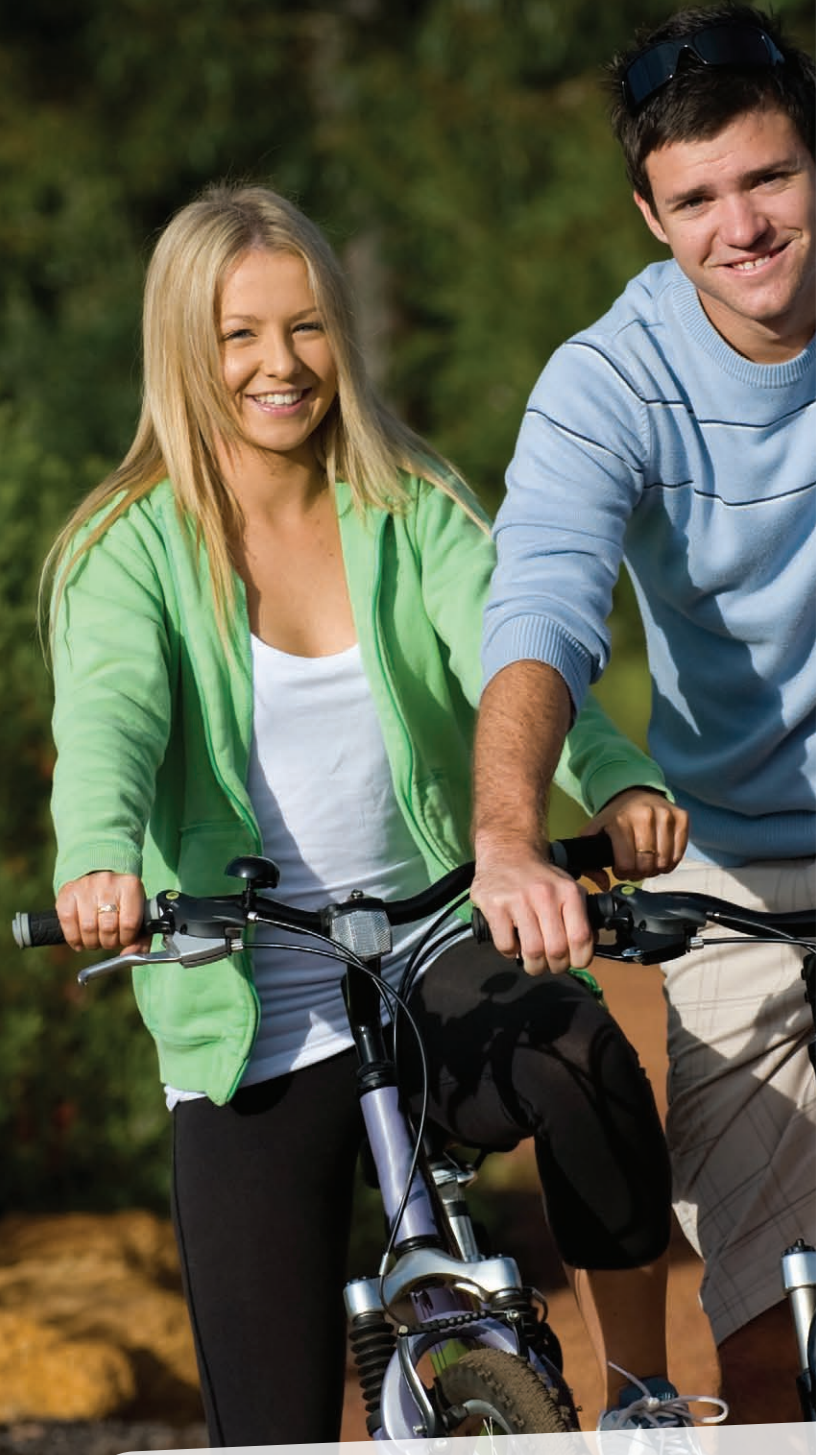
Anthem BlueCross BlueShield

Individual and Family Health Care Plans
for Nevada

Our plans fit your plans

Lumenos® HSA Plus

NVBR11006XLS Rev. 5/12



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:

- **One of the largest provider networks in Nevada.**
  With more than 2,500 doctors and nearly 40 hospitals throughout the state, chances are your doctor is one of ours.
- **A choice of plans to fit your budget and lifestyle.**
  No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- **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.

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.)

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 more than 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 cost, 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 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 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 in-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.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high-deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

Lumenos® HSA Plus

Is this the right plan for you?

Lumenos HSA Plus health plans were designed to give you more control over your health care costs. They help you focus on getting healthy and staying that way.

Lumenos HSA Plus Plan Highlights

This plan offers traditional health care benefits that can be paired with a Health Savings Account (HSA) for more flexibility and potential tax advantages. Simple plan designs make using them that much easier.

Features:

- Preventive care benefits help focus on keeping you healthy.
- PPO health plan coverage with a large array of benefits after you pay your deductible.
- Network services covered 100% after you meet your deductible.
- Coverage compatible with an HSA that is yours to fund and keep if you choose. Use the HSA for qualified medical expenses or as a savings vehicle. Just contact your tax advisor for possible advantages.
- Special programs for Smoking Cessation and Weight Management.
- Access to our 24-hour Nurse Line.
- Online tools for a personalized Health Assessment, prescription drug cost comparison, and other tools to give you more control.

You should know:

- Your Lumenos HSA Plus plan has a policy-level deductible and out-of-pocket maximum. Once any combination of covered members on the policy meet these amounts, the plan pays 100% of covered expenses. It's that simple.
- While Lumenos HSA Plus is compatible with a Health Savings Account, your health care plan works with or without it. You may set up the HSA now, later, or not at all. It's your choice.

Prescription Drug Coverage

Lumenos HSA Plus not only puts you in charge of your health care dollars, it can help you use those dollars for generic and brand name prescription drugs in the way that best suits you.

Once your deductible is met, covered prescription drugs are covered at 100%. But even while you are meeting your deductible, you benefit from lower negotiated rates on prescription drugs at network pharmacies nationwide. There's no need to have a different deductible or copayment for prescriptions; it all works as one.

And since you decide how to spend it, your Health Savings Account dollars can be used to pay for prescription drugs while you are meeting your deductible.

How to Customize your Lumenos HSA Plus Plan

Choose your deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you. Remember, any covered member can contribute to some or all of the policy deductible and out-of-pocket maximum, whether the policy covers one member or a whole houseful.

Use your Health Savings Account the way you want: Your HSA, if you choose to open one, is funded by you. So, it is yours to use for qualified health care expenses covered by the plan, or those not covered at all, like contact lenses. Your HSA is also yours to keep if you ever leave the plan; you won't lose those dollars if they're not used. In fact, the carryover from year to year can help you save for future financial needs. See the enclosed insert from our preferred banking partner for more information.

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.

Benefits

Lumenos® HSA Plus

Calendar Year Deductible

Your Choices

		SINGLE POLICY COVERAGE:			FAMILY POLICY COVERAGE:		FAMILY POLICY COVERAGE:	
Individual	NETWORK:	$3,000	$4,500	$5,950	N/A	N/A	N/A	N/A
	NON-NETWORK:	$3,000	$4,500	$5,950	N/A	N/A	N/A	N/A
Family	NETWORK:	N/A	N/A	N/A	$3,500	$5,500	$7,500	$11,900
	NON-NETWORK:	N/A	N/A	N/A	$3,500	$5,500	$7,500	$11,900
Network Coinsurance Options		0%	0%	0%	0%	0%	0%	0%

Calendar Year Out-of-Pocket Maximum

Add Your Chosen Deductible to the Amount Below

		SINGLE POLICY COVERAGE:			FAMILY POLICY COVERAGE:		FAMILY POLICY COVERAGE:	
Individual	NETWORK:	$0	$0	$0	N/A	N/A	N/A	N/A
	NON-NETWORK:	$3,000	$4,500	$5,950	N/A	N/A	N/A	N/A
Family	NETWORK:	N/A	N/A	N/A	$0	$0	$0	$0
	NON-NETWORK:	N/A	N/A	N/A	$3,500	$5,500	$7,500	$11,900
How family deductibles and family out-of-pocket maximums work		Not applicable for Single policy coverage			Either one or more members must meet the family deductible. The family out-of-pocket maximum can be met by either one or more members. Once the maximum is met, no additional coinsurance will be required for the family for remainder of the calendar year.		Once one family member reaches half the family 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. Once the maximum is met, no additional coinsurance will be required for the family for remainder of the calendar year.	

Plan Lifetime Maximum

None

Covered Services

Your Share of Costs (after deductible, unless not subject to deductible)

Doctors' Office Visits	NETWORK: 0% Coinsurance NON-NETWORK: 30% Coinsurance
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	NETWORK: 0% Coinsurance NON-NETWORK: 30% Coinsurance
Inpatient Services (overnight hospital/facility stays)	NETWORK: 0% Coinsurance NON-NETWORK: 30% Coinsurance
Outpatient Services (without overnight hospital/facility stays)	NETWORK: 0% Coinsurance NON-NETWORK: 30% Coinsurance
Emergency Room Services	NETWORK: 0% Coinsurance NON-NETWORK: 0% 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: 30% Coinsurance
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life, Autism benefits

Prescription Drug Coverage

Lumenos HSA Plus

Retail Drugs (and Home Delivery Mail Order Drugs when available)	NETWORK: 0% Coinsurance NON-NETWORK: 30% Coinsurance
Optional Drug Coverage (when available)	Not Available
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Substance Abuse, Therapy Services, 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 Contract/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.

NOTES:

- 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.
- Lumenos HSA plans feature a combined medical/pharmacy deductible so your payments for prescription drugs also apply toward your plan deductible and out-of-pocket maximum.

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.

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 *(cleanings limited to two per member per year)*	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 and indicate your beneficiary.

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 Blue Cross and Blue Shield 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.

Anthem BlueCross BlueShield

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 from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem agent.

This brochure is intended as a brief summary of benefits and services; it is not your Certificate/Summary of Benefits. If there is any difference between this brochure and your Certificate/Summary of Benefits, the provisions of the Certificate/Summary of Benefits 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!

After 9/23/12, to view a Summary of Benefits and Coverage please visit www.healthcare.gov.

Stay focused on your fitness.

Anthem BlueCross BlueShield

Let ACS | BNY Mellon handle the finances.

You're only one checkmark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a Welcome Kit to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

Setting up a Health Savings Account

The Lumenos® HSA plans are a nice way to save on premiums. But that's just the tip of the savings iceberg. To realize your plan's full financial power, consider opening a health savings account to go with your Lumenos plan. The portability and tax savings of an HSA account can add up fast.

We've joined with Affiliated Computer Services (ACS) and The Bank of New York Mellon (BNY Mellon) to integrate their HSA accounts with our Lumenos HSA plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences:

- A single customer service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account

Of course, if you'd rather use another financial institution for your account, that's fine too.

CONVFLY16001MS Rev. 9/12

A closer look

HSA Welcome Kit

If you make the selection on your application form, your Health Savings Account will automatically be set up once you're approved for the Lumenos HSA plan — no set up fee required, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using your account. A separate application for your account is only required if you choose a financial institution other than BNY Mellon.

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSAcompatible high deductible health plan (such as the Lumenos HSA plan).
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other medical plan that is not an HSA-compatible high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- If you are a veteran, you may not have received veteran's benefits within the last three months.
- You cannot be active military.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $1,000 HSA balance. Investment options include a number of mutual families. Once you're ready to invest, just call the ACS | BNY Mellon HSA Solution Contact Center at **866-686-4798** Monday through Friday from 8 a.m. to 8 p.m. (Eastern Time) for a prospectus with more details.

Debit cards, checkbooks and online banking

You can use your MasterCard® debit card, your HSA checkbook, or our new online banking option (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses, or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statements

Each month, you'll receive a statement from BNY Mellon that shows all of your account activity. For an additional fee of $0.75 per month, you can receive a paper statement. Please go to anthem.com or call your dedicated Customer Service to learn how to elect this option. You'll also receive IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

ACS | BNY Mellon HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As good as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	$2.95
First 2 debit cards	no charge
Debit card transactions	no charge
Check writing	no charge
ATM transactions	$1
Card replacement	$5
Check reorder	$10
Non-sufficient funds	$25
Stop check service	$25
Duplicate check	$5
Periodic paper statement	$0.75

Nevada Coverage Details

Things you need to know before you buy...

Anthem Health. **Join In.**

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.

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.

Lumenos® Plus HSA-Compatible Plan for Individuals
$3,000; 4,500; 5,950; 3,500; 5,500; 7,500, 11,900
Summary of Benefits

Anthem Health. **Join In.**

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. The Deductible applies to all covered services unless specifically stated otherwise. **Coinsurance options reflect the percentage of the allowable charge the covered person will pay.**

	In-Network	Out-of-Network
Deductible Applicable only to specified covered services (Separate deductibles for In-Network and Out-of-Network) Prescription drug expenses apply towards the Annual Deductible.	**Individual Coverage Only:** $3,000; $4,500; $5,950 After the individual deductible is satisfied, no further deductible is required for the remainder of that calendar year. **Family coverage not provided** **Aggregate Family Deductible** **Family Coverage:** $3,500; $5,500 Under a family membership (two (2) or more members enrolled), no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: When one family member has satisfied the family deductible, that family member and all other family members are eligible for benefits. When no family member meets the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits for the remainder of that calendar year. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year.	**Individual Coverage Only:** $3,000; $4,500; $5,950 After the individual deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum benefit allowance. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum benefit allowance or where specifically noted in the Certificate and *Summary of Benefits*. Charges in excess of the maximum benefit allowance will not be applied toward the deductible. **Family coverage not provided** **Aggregate Family Deductible** **Family Coverage:** $3,500; $5,500 Under a family membership (two (2) or more members enrolled), no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: When one family member has satisfied the family deductible, that family member and all other family members are eligible for benefits. When no family member meets the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits for the remainder of that calendar year. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum benefit allowance. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum benefit allowance or where specifically noted in the Certificate and *Summary of Benefits*. Charges in excess of the maximum benefit allowance will not be applied toward the deductible.

	In-Network	Out-of-Network
	Embedded Family Deductible **Family Coverage:** $7,500; $11,900 Once the total of allowable charges applying to the deductible for two (2) or more members equal the family deductible, no further deductible will be required for all enrolled members for the remainder of that calendar year. However, no one member can contribute more than half of the family deductible amount to satisfy the family deductible. If an individual family member has satisfied one half of the Embedded Family Deductible, that individual family member only has then satisfied the Embedded Family Deductible for the current plan year with respect to any future claims by that family member. However, until 100% of the Embedded Family Deductible amount has been satisfied, it will continue to apply to all other family members. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year.	**Embedded Family Deductible** **Family Coverage:** $7,500; $11,900 Once the total of allowable charges applying to the deductible for two (2) or more members equal the family deductible, no further deductible will be required for all enrolled members for the remainder of that calendar year. However, no one member can contribute more than half of the family deductible amount to satisfy the family deductible. If an individual family member has satisfied one half of the Embedded Family Deductible, that individual family member only has then satisfied the Embedded Family Deductible for the current plan year with respect to any future claims by that family member. However, until 100% of the Embedded Family Deductible amount has been satisfied, it will continue to apply to all other family members. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum benefit allowance. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum benefit allowance or where specifically noted in the Certificate and *Summary of Benefits*. Charges in excess of the maximum benefit allowance will not be applied toward the deductible.
Out-of-Pocket Annual Maximum The Out-of-Pocket Annual Maximums includes the deductible but are separate for in- and out-of-network. Prescription drug expenses apply towards the Out-of-Pocket Annual Maximum.	**Individual Coverage:** $3,000; $4,500; $5,950 **Family coverage not provided**	**Individual Coverage:** $6,000; $9,000; $11,900 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. **Family coverage not provided**

	In-Network	Out-of-Network
	Aggregate Family Out-of-Pocket Maximum **Family Coverage:** $3,500; $5,500 Under a family membership, when one family member has satisfied the family out-of-pocket annual maximum, that family member and all other family members have satisfied the out-of-pocket annual maximum for that calendar year. When no family member meets the family out-of-pocket annual maximum on their own, but the family members collectively meet the entire family out-of-pocket annual maximum, then all family members will have satisfied the out-of-pocket annual maximum. The individual out-of-pocket maximum does not apply under a family membership.	**Aggregate Family Out-of-Pocket Maximum** **Family Coverage:** $7,000; $11,000 Under a family membership, when one family member has satisfied the family out-of-pocket annual maximum, that family member and all other family members have satisfied the out-of-pocket annual maximum for that calendar year. When no family member meets the family out-of-pocket annual maximum on their own, but the family members collectively meet the entire family out-of-pocket annual maximum, then all family members will have satisfied the out-of-pocket annual maximum and all family members will be eligible for benefits for the remainder of that year. 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 or where specifically noted in the certificate or Summary of Benefits do not count towards satisfying the Out of Pocket Annual Maximum. Note: The individual out-of-pocket maximum does not apply under a family membership.

	In-Network	Out-of-Network
	Embedded Family Out-of-Pocket Maximum **Family Coverage:** $7,500; $11,900 Once the total of allowable charges applying to the Individual Out of Pocket Annual Maximum for two (2) or more members in a Family contract equal the Family Out of Pocket Annual Maximum, no family member will be required to pay deductible or coinsurance amounts, except as otherwise required by this Certificate or the *Summary of Benefits* for the remainder of that calendar year. However, no one person can contribute more than half of the Family Out-of-Pocket Annual Maximum to satisfy the Family Out-of-Pocket Annual Maximum. If an individual family member has satisfied one half of the Family Out-of-Pocket Annual Maximum, that individual family member only has then satisfied the Out-of-Pocket Annual Maximum for the current plan year with respect to any future claims by that family member. However, until 100% of the Family Out-of-Pocket Annual Maximum amount has been satisfied, it will continue to apply to all other family members.	**Embedded Family Out-of-Pocket Maximum** **Family Coverage:** $15,000; $23,800 Once the total of allowable charges applying to the Individual Out of Pocket Annual Maximum for two (2) or more members in a Family contract equal the Family Out of Pocket Annual Maximum, no family member will be required to pay deductible or coinsurance amounts for the remainder of that calendar year except as otherwise required by the Certificate or this Summary of Benefits. No one person can contribute more than half of the Family Out-of-Pocket Annual Maximum amount to satisfy the Family Out-of-Pocket Annual Maximum. If an individual family member has satisfied one half of the Family Out-of-Pocket Annual Maximum, that individual family member only has then satisfied the Out-of-Pocket Annual Maximum for the current plan year with respect to any future claims by that family member. However, until 100% of the Family Out-of-Pocket Annual Maximum amount has been satisfied, it will continue to apply to all other family members. 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 or those charges specifically noted in the certificate or Health Benefit Plan Description Form do not count towards satisfying the Out of Pocket Annual Maximum.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Physician Visits			Services covered as part of an office visit include: • History (gathering of information on an illness or injury) • Examination • Medical decision making (the physician's actual diagnosis and treatment plan) 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.
Inpatient/Outpatient	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Office Visit	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Preventive Care	Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many 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 These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 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 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.	A Children - age-appropriate visits and routine immunizations B Adults - mammography - cervical cancer screening (pap smear) - prostate screening - colorectal cancer screening - immunizations against cervical cancer 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Professional services are services provided during a physician office-based visit, include, but are not limited to laboratory, X-ray, radiology and pathology services. Please refer to the Professional Services section of the certificate for a full description of covered professional services. Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Services billed by a hospital are included in the hospital inpatient/outpatient benefits.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Maternity Care	Not covered	Not covered	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
Physical Rehabilitation (Physical therapy, occupational therapy, cardiac rehabilitation and speech therapy)	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Each calendar year physical rehabilitation is limited to twelve (12) visits for physical therapy, twelve (12) visits for occupational therapy, and/or twelve (12) visits for speech therapy. Physical rehabilitation visit limits are combined for services received from in-network and out-of-network providers. Benefits for cardiac rehabilitation are paid up to thirty six (36) visits. The program must start within three (3) months of the major cardiac event and be completed within six (6) months of the major cardiac event.
Speech Therapy	Covered under Physical Rehabilitation as specified above.	Covered under Physical Rehabilitation as specified above.	
Spinal Manipulations and Acupuncture	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Each year spinal manipulations and acupuncture are limited to twelve (12) visits per calendar year; in-network and out-of-network combined.
Hospital Care Inpatient/Outpatient Surgery and Outpatient Non-emergency	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Emergency Care	No coinsurance after deductible.	No coinsurance after deductible.	
Ambulance Services Ground Services/Air Services			Benefits are paid for medically necessary ground or air ambulance transportation.
In the event of a medical emergency	No coinsurance after deductible.	No coinsurance after deductible.	
Other than in a medical emergency	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Alcohol and Drug Abuse	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Severe Mental Illness (Severe mental illnesses are: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder)			
a) Inpatient	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Anthem will cover up to forty (40) inpatient days, or eighty (80) partial days (combined).
b) Outpatient	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Anthem will cover up to forty (40) visits per calendar year for outpatient services.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	No coinsurance after deductible.	30% coinsurance after deductible, plus 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; 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	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Benefits are limited to one hundred (100) visits per member per calendar year; in and out-of-network combined.
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Skilled Nursing Facility	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Benefits are limited to one hundred (100) days per member per calendar year; in- and out-of-network combined.
Hospice Care	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Human Organ and Tissue Transplant Services	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	See certificate for details on covered transplants.
Temporomandibular Joint Syndrome (TMJ)	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Enteral Formula and Special Foods	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Prescription Drugs	No coinsurance after deductible for each prescription and/or refill.	30% coinsurance after deductible, plus the difference in cost between the pharmacy cash price and the allowed charge for each prescription and/or refill.	Please refer to the Prescription Drug section of the certificate for a full description of covered prescription drug benefits. Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with emergency care.

DENTAL INJURY:	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.
DEPENDENT ELIGIBILITY:	The end of the month in which the dependent child becomes age 26.
PREAUTHORIZATION:	**Inpatient Services:** Hospital (medical and surgical care) and Hospice Care services are subject to preauthorization. **Outpatient Services:** Outpatient surgeries in a Hospital are subject to preauthorization.

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 Lumenos® Plus (HSA-Compatible) Plan for Individuals
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 in patient 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, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization (BEST), clonics 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 services 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.
- Spinal manipulations and acupuncture are limited to twelve (12) visits per calendar year, in-network and out-of-network combined.
- Each calendar year, physical rehabilitation is limited to twelve (12) visits for physical therapy, twelve (12) visits for occupational therapy, and/or twelve (12) visits for speech therapy; in-network 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.
- 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-network 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 one hundred (100) visits per member per calendar year, in-network and out-of-network combined.
- Skilled nursing facility services benefits are limited to one hundred (100) days per member per calendar year; in-network 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 the month following his or her birthday.
- 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.

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):

_____

_____

_____