Anthem BlueCross BlueShield

Individual and Family Health Care Plans
for Nevada

Our plans fit your plans

SmartSense® Plus Premier

NVBR11003SPR Rev. 2/13

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.

Since 1969, Anthem has provided health care coverage and security to our Nevada neighbors. And now, we're pleased to offer these same individual health care plans with 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.

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.

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 coverage 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.
  - *Estimate Your Cost:* 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!

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

* 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 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.

SmartSense® Plus

Is this the right plan for you?

SmartSense Plus was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

Prescription Drug Coverage

The cost of prescription drugs can be overwhelming, so SmartSense Plus includes prescription drug coverage to help you manage those costs.

SmartSense Plus prescription drug coverage includes the following tiers which represent a cost level within the generic and brand name prescription drug categories.

- **Drug Formulary:** This is a special list of prescription drugs the SmartSense plan covers. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes from the Plan Formulary.
- **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:** These drugs have a higher copay than those in Tier 2 and include non-formulary brand name medications.
- **Specialty:** These are typically high-cost, scientifically engineered drugs and are paid at a coinsurance level instead of copay.

SmartSense Plus Plan Highlights

SmartSense Plus offers affordable price options, solid protection that covers essentials and even some immediate benefits before the deductible.

Features:

- First three Doctors' Office Visits with predictable copays, per plan member, each calendar year before having to meet your deductible.
- Preventive care benefits help focus on keeping you healthy.
- Choice of two prescription drug coverage options.

You should know:

- After first three Doctors' Office Visits, all other visits are covered after the deductible.
- Maternity benefits are not included with this plan.

How to Customize your SmartSense Plus Plan

With SmartSense Plus, you have some choice and flexibility to change the plan to better meet your needs. SmartSense 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.

Upgrade Drug Coverage: By choosing the Upgrade Drug Coverage option (for an additional cost) you can lower your prescription drug deductible to $500, instead of the $7,500 prescription drug deductible (for Tier 2, 3 and Specialty) included in the standard drug coverage 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.

Anthem BlueCross BlueShield

Benefit Guide for Nevada

Benefits		SmartSense® Plus				
Calendar Year Deductible		**Your Choices**				
Individual	NETWORK:	$1,000	$2,000	$3,500	$5,500	$7,000
	NON-NETWORK:	$1,000	$2,000	$3,500	$5,500	$7,000
Family	NETWORK:	$2,000	$4,000	$7,000	$11,000	$14,000
	NON-NETWORK:	$2,000	$4,000	$7,000	$11,000	$14,000
Network Coinsurance Options		30%	30%	30%	30%	30%
Calendar Year Out-of-Pocket Maximum		**Add Your Chosen Deductible to the Amount Below**				
Individual	NETWORK:	$2,500	$2,500	$2,500	$2,500	$2,500
	NON-NETWORK:	$6,000	$7,000	$8,500	$10,000	$10,000
Family	NETWORK:	$5,000	$5,000	$5,000	$5,000	$5,000
	NON-NETWORK:	$12,000	$14,000	$17,000	$20,000	$20,000
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.				
Plan Lifetime Maximum		None				

Covered Services	Your Share of Costs (after deductible, unless waived)
Doctors' Office Visits	**NETWORK:** · **First 3 Office Visits** (per member): **$30 Copay,** deductible waived · **Additional Office Visits: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Inpatient Services (overnight hospital/facility stays)	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Outpatient Services (without overnight hospital/facility stays)	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Emergency Room Services	**NETWORK: 30% Coinsurance** **NON-NETWORK: 30% 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: 50% Coinsurance**
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life, Autism benefits

Prescription Drug Coverage	SmartSense Plus
Retail Drugs (and Mail Order Drugs when available)	**Standard Drug Coverage:** **Tier 1 (Generic drugs): $15 Copay** $7,500 annual Prescription Drug deductible per member applies before the following: ∘ **Tier 2 (Formulary Brand name drugs): $40 Copay** ∘ **Tier 3 (Non-Formulary Brand name drugs): $60 Copay** ∘ **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. **NON-NETWORK:** Same benefits as network, plus any difference between the actual charges and Anthem's allowed amount.
Optional Drug Coverage (when available)	**Upgrade Drug Coverage:** **Tier 1 (Generic drugs): $15 Copay** $500 annual Prescription Drug deductible per member applies before the following: ∘ **Tier 2 (Formulary Brand name drugs): $40 Copay** ∘ **Tier 3 (Non-Formulary Brand name drugs): $60 Copay** ∘ **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 $500 annual deductible. **NON-NETWORK:** Same benefits as network, plus any difference between the actual charges and Anthem's allowed amount.
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.	NOTES: - Discounted 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.

Premier

Is this the right plan for you?

Premier is a great choice for families or for individuals looking for robust benefits for both routine and unexpected medical care.

Prescription Drug Coverage

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

Premier prescription drug coverage includes the following tiers which represent a cost level within the generic and brand name prescription drug categories.

- **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:** These drugs have a higher copay than those in Tier 2 and include non-formulary brand name medications.
- **Specialty:** These are typically high-cost, scientifically engineered drugs and are paid at a coinsurance level instead of copay.

How to Customize your Premier Plan

With Premier you have some choice and flexibility to change the plan to better meet your needs. Premier 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.

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.

Premier Plan Highlights

Premier offers many benefits before the deductible and prescription drugs. The lowest levels of coinsurance across all deductibles gives Premier added value over other plans we offer.

Features:

- Unlimited Doctors' Office Visits with predictable copays, before the deductible.
- Preventive care benefits help focus on keeping you healthy.
- Annual routine eye exam.

You should know:

- Premier offers one of our highest levels of benefits, so the premiums are typically more than our other plans.
- Maternity benefits are not included with this plan.

Anthem BlueCross BlueShield

Benefit Guide for Nevada

Benefits — Premier

Calendar Year Deductible		Your Choices					
Individual	NETWORK:	$1,000	$1,500	$2,500	$3,500	$5,000	$6,000
	NON-NETWORK:	$1,000	$1,500	$2,500	$3,500	$5,000	$6,000
Family	NETWORK:	$2,000	$3,000	$5,000	$7,000	$10,000	$12,000
	NON-NETWORK:	$2,000	$3,000	$5,000	$7,000	$10,000	$12,000
Network Coinsurance Options		25%	25%	25%	25%	25%	25%
Calendar Year Out-of-Pocket Maximum		**Add Your Chosen Deductible to the Amount Below**					
Individual	NETWORK:	$4,500	$4,500	$4,500	$4,500	$4,500	$4,500
	NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family	NETWORK:	$9,000	$9,000	$9,000	$9,000	$9,000	$9,000
	NON-NETWORK:	$15,000	$15,000	$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.
Plan Lifetime Maximum	None

Covered Services	Your Share of Costs (after deductible, unless waived)
Doctors' Office Visits	NETWORK: **Office Visit $30 Copay** for primary care physician; **$50 Copay** for specialist (deductible waived for both) NON-NETWORK: **50% Coinsurance**
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	NETWORK: **25% Coinsurance** NON-NETWORK: **50% Coinsurance**
Inpatient Services (overnight hospital/facility stays)	NETWORK: **25% Coinsurance** NON-NETWORK: **50% Coinsurance**
Outpatient Services (without overnight hospital/facility stays)	NETWORK: **25% Coinsurance** NON-NETWORK: **50% Coinsurance**
Emergency Room Services	NETWORK: **25% Coinsurance** NON-NETWORK: **25% 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: **50% Coinsurance**
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life, Autism benefits

Prescription Drug Coverage	Premier
Retail Drugs (and Mail Order Drugs when available)	NETWORK: **Tier 1 (Generic Drugs): $15 Copay** $500 annual Prescription Drug deductible per member applies before the following: ∘ **Tier 2 (Formulary Brand Name Drugs): $40 Copay** ∘ **Tier 3 (Non-Formulary Brand Name Drugs): $60 Copay** ∘ **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 $500 annual deductible. **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 Applicable
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Services, Home Health Care, Severe Mental Health, Physical/Occupational Therapy, Urgent Care, Vision Exam

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.

NOTES:
- Discounted 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.

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 our 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!

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!

To view a Summary of Benefits and Coverage please visit www.healthcare.gov.

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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

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- 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.

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Nevada Individual SmartSense Plus Standard Upgrade Rx 1,000; 2,000; 3,500; 5,500; 7,000 Summary of Benefits

Anthem BlueCross BlueShield

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	
Medical Deductible Applicable only to specified services (Not combined for In-Network and Out-of-Network)	**Individual:** $1,000; $2,000; $3,500; $5,500; $7,000	**Family Maximum:** $2,000; $4,000; $7,000; $11,000; $14,000	**Individual:** $1,000; $2,000; $3,500; $5,500; $7,000	**Family Maximum:** $2,000; $4,000; $7,000; $11,000; $14,000
	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 deductible amount.		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 deductible amount. 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 Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.	
	Prescription drug expenses do not apply towards this deductible. Copayment amounts do not apply to the deductible.			

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	In-Network		Out-of-Network	
Out-of-Pocket Annual Maximum The Out-of-Pocket Annual Maximum includes the deductible but is not combined for in- and out-of-network.	**Individual:** $3,500; $4,500; $6,000; $8,000; $9,500	**Family:** $7,000; $9,000; $12,000; $16,000; $19,000	**Individual:** $7,000; $9,000; $12,000; $15,500; $17,000	**Family:** $14,000; $18,000; $24,000; $31,000; $34,000
	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, **except** 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. 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.	
	Prescription drug expenses do not apply towards this Out of Pocket maximum. Copayment amounts do not apply to the out of pocket maximum.			

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Physician Visits Inpatient/Outpatient	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	The first three (3) In-Network office visits are subject to a $30 copayment and are available to be used for routine, preventive or out patient non-severe mental health care.
Office Visit	$30 copayment per office visit for the first three (3) office visits in a calendar year; then 30% coinsurance after deductible.	50% coinsurance plus all charges in excess of the maximum benefit allowance.	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 services are subject to applicable deductible, coinsurance, or cost sharing. Copayment amounts do not apply to the deductible or the out of pocket maximum.

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. 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.	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.	50% coinsurance plus all charges in excess of the maximum benefit allowance.	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	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
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 spinal manipulation)	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	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.
Speech Therapy	30% coinsurance	50% coinsurance plus 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.
Spinal Manipulations	Covered under Physical Rehabilitation as specified above.	Covered under Physical Rehabilitation as specified above.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Acupuncture	Not Covered	Not Covered	
Hospital Care Inpatient/Outpatient Surgery and Outpatient Non-emergency	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Emergency Care	30% coinsurance	30% coinsurance.	
Ambulance Services Ground Services/Air Services			Benefits are paid for medically necessary ground or air ambulance transportation.
In a medical emergency	30% coinsurance	30% coinsurance	
Other than in a medical emergency	30% coinsurance	50% coinsurance	
Alcohol and Drug Abuse	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Mental Illness Care & Severe Mental Illnesses (Severe mental illnesses are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder)			
a) Inpatient	30% coinsurance	50% coinsurance 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	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Anthem will cover up to forty (40) visits per calendar year for outpatient services.
Non-Severe Mental Health a) Inpatient	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Anthem will cover up to forty (40) inpatient days per calendar year for inpatient services.
b) Outpatient	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Anthem will cover up to forty (40) visits per calendar year for outpatient services. The first three (3) In-Network office visits are subject to a $30 copayment and are available to be used for routine, preventive or out patient non-severe mental health care.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	30% coinsurance	50% coinsurance 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	30% coinsurance	Plan pays 50% coinsurance plus all charges in excess of the maximum benefit allowance.	Benefits are limited to sixty (60) visits per member per calendar year; in and out-of-network combined.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Skilled Nursing Facility	30% coinsurance	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.
Hospice Care	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Human Organ and Tissue Transplant Services	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	See certificate for details on covered transplants.
Temporomandibular Joint Syndrome (TMJ)	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Enteral Formula and Special Foods	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	

Prescription Drugs **Note:** • The StandardRx Option has the $7,500 Tier 2 and Tier 3 Prescription Drug Deductible. • The UpgradeRx Option has the $500 Tier 2 and Tier 3 Prescription Drug Deductible.	**Participating Retail Pharmacy:** • **Tier 1 Prescription Drugs:** $15 copayment for each prescription and/or refill for a maximum thirty (30) day supply. • **Tier 2 Prescription Drugs:** After the $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $40 copayment for each prescription and/or refill for a maximum thirty (30) day supply. • **Tier 3 Prescription Drugs:** After the $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $60 copayment for each prescription and/or refill for a maximum thirty (30) day supply. • **Tier 3 Specialty Prescription Drugs:** After the $500; 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. **Tier 3 includes Specialty Prescription Drugs.*** ***Specialty Prescription Drugs** 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. **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.** **Tier 2 and Tier 3 Prescription Drug Deductible** Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of $500; 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. **Note:** • Copayments for the Tier 2 and Tier 3 deductible **will not** 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. • The Tier 2 and Tier 3 Drug Deductible **will not** accumulate to satisfy the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum. **Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum:** There is a $2,500 Tier 3 Out-of-Pocket Maximum for specialty prescription drugs per member per calendar year when purchased from participating pharmacies (preferred specialty pharmacies). You will not be required to pay more than $2,500 per calendar year for specialty prescription drugs purchased from participating pharmacies (preferred specialty pharmacies). Once the $2,500 Tier 3 Specialty Out-of-Pocket Maximum is met, no further copayments or coinsurance will be required for covered specialty prescriptions obtained from participating pharmacies (preferred specialty pharmacies), for the remainder of that calendar year. **Note:** • Copayments for Tier 1 and Tier 2 drugs **will not** 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. • The Tier 2 and 3 Prescription Drug Deductible does not accumulate to satisfy the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum. • The Tier 3 Specialty 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.
Note: • The StandardRx Option has the $7,500 Tier 2 and Tier 3 Prescription Drug Deductible. • The UpgradeRx Option has the $500 Tier 2 and Tier 3 Prescription Drug Deductible.	**Mail Order:** • **Tier 1 Prescription Drugs:** $45 copayment for each prescription and/or refill for each ninety (90) day supply. • **Tier 2 Prescription Drugs:** After a $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $120 copayment for each prescription and/or refill for each ninety (90) day supply. • **Tier 3 Prescription Drugs:** After a $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $180 copayment for each prescription and/or refill for each ninety (90) day supply. • **Tier 3 Specialty Prescription Drugs:** After a $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible is satisfied, 25% coinsurance for each prescription and/or refill up to a maximum thirty (30) day supply. **Note:** Specialty Drugs are limited to a thirty (30) day supply.

Prescription Drugs (continued)	**Out-of-Network (Retail or Mail-Order) Pharmacy:** Please see the Member Benefits section in your Certificate for information on how to file a claim from an out-of-network pharmacy. • **Tier 1 Prescription Drugs:** ○ $15 copayment, **plus** 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. ○ $45 copayment **plus** 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. • **Tier 2 Prescription Drugs:** ○ After the $500; 7,500 Tier 2 and Tier3 Prescription Drug Deductible has been satisfied, $40 copayment, **plus** 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. ○ After a $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $120 copayment **plus** 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. • **Tier 3 Prescription Drugs:** ○ After the $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $60 copayment, **plus** 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. ○ After a $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible is satisfied, $180 copayment **plus** 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. • **Tier 3 Specialty Prescription Drugs:** ○ After the $500; 7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, 25% coinsurance, **plus** 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. **Note:** Specialty Drugs are limited to a thirty (30) day supply. **Non-Formulary Prescription Drugs:** Charges for non-formulary prescription drugs will not be applied towards the Tier 2 and Tier 3 Prescription Drug Deductible or the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum. • 100% of the contracted amount if purchased from a participating pharmacy. • 100% of the cash price if purchased from a non-participating pharmacy. 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 SmartSense Plus Standard Upgrade Rx 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.

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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, acupuncture, 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.
- Autism — This coverage does not cover any services for autism.
- 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 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.
- 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, speech therapy, and/or chiropractic therapy; in- and out-of-network combined.
- Benefits for speech therapy are paid up to twenty (20) visits per calendar year; in- and out-of-network combined.
- Severe mental health benefits are limited to:
  - Anthem will cover up to forty (40) inpatient days, or eighty (80) partial days (combined).
  - Anthem will cover up to forty (40) visits per calendar year for outpatient services.
- Non severe mental health benefits are limited to:
  - Anthem will cover up to forty (40) visits per calendar year for inpatient services.
  - Anthem will cover up to forty (40) visits per calendar year for outpatient services.
- 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 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.

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):

_____

_____

_____

Nevada Individual Premier Plan
$1,000; 1,500; 2,500; 3,500; 5,000; 6,000
Summary of Benefits

Anthem BlueCross BlueShield

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	
Medical Deductible Applicable only to specified services (Not combined for In-Network and Out-of-Network)	**Individual:** $1,000; $1,500; $2,500; $3,500; $5,000; $6,000	**Family Maximum:** $2,000; $3,000; $5,000; $7,000; $10,000; $12,000	**Individual:** $1,000; $1,500; $2,500; $3,500; $5,000; $6,000	**Family Maximum:** $2,000; $3,000; $5,000; $7,000; $10,000; $12,000
	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 deductible amount.		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 deductible amount. 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 Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.	
	Copayment amounts do not apply to the deductible.			

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® Registered marks Blue Cross and Blue Shield Association

	In-Network		Out-of-Network	
Out-of-Pocket Annual Maximum The Out-of-Pocket Annual Maximum includes the deductible but is not combined for in- and out-of-network.	**Individual:** $5,500; $6,000; $7,000; $8,000; $9,500; $10,500	**Family:** $11,000; $12,000; $14,000; $16,000; $19,000; $21,000	**Individual:** $8,500; $9,000; $10,000; $11,000; $12,500; $13,500	**Family:** $17,000; $18,000; $20,000; $22,000; $25,000; $27,000
	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, **except** 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. 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 maximum.			

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Physician Visits Inpatient/Outpatient	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	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 services are subject to applicable deductible, coinsurance, or cost sharing. Copayment amounts do not apply to the deductible or the out of pocket maximum.
Office Visit Primary Care Providers Specialists	$30 copayment $50 copayment	50% coinsurance plus all charges in excess of the maximum benefit allowance.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Preventive Care Services 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: 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.	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.	After the deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum benefit allowance.	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) 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 see 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.
Routine Vision Services (Routine eye exam)	$20 copayment	Maximum Anthem payment of $35	One routine eye examination per member once every 12 months; in- and out-of-network combined.
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
Maternity Care	Not covered	Not covered	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Physical Rehabilitation (Physical therapy, occupational therapy, cardiac rehabilitation, and spinal manipulation)	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	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 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.
Speech Therapy	25% coinsurance	50% coinsurance plus 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.
Spinal Manipulations	Covered under Physical Rehabilitation as specified above.	Covered under Physical Rehabilitation as specified above.	
Acupuncture	Not Covered	Not Covered	
Hospital Care Inpatient/Outpatient Surgery and Outpatient Non-emergency	25% coinsurance	50% plus all charges in excess of the maximum benefit allowance.	
Emergency Care	25% coinsurance	25% coinsurance	
Ambulance Services Ground Services/Air Services			Benefits are paid for medically necessary ground or air ambulance transportation.
In the event of a medical emergency	25% coinsurance	25% coinsurance	
Other than in a medical emergency	25% coinsurance	50% coinsurance	
Alcohol and Drug Abuse	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Severe Mental Illness (Severe mental illnesses are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder)			
a) Inpatient	25% coinsurance	50% coinsurance 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) excluding visits for the management of medications.
b) Outpatient	25% coinsurance	50% coinsurance 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	25% coinsurance	50% coinsurance 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 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.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Home Health Care	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Benefits are limited to sixty (60) visits per member per calendar year in and out-of-network combined.
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Skilled Nursing Facility	25% coinsurance	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
Hospice Care	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Human Organ and Tissue Transplant Services	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	See certificate for details on covered transplants.
Temporomandibular Joint Syndrome (TMJ)	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	
Enteral Formula and Special Foods	25% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	

Prescription Drugs	**Participating Retail Pharmacy:** • **Tier 1 Prescription Drugs:** $15 copayment for each prescription and/or refill for a maximum thirty (30) day supply. • **Tier 2 Prescription Drugs:** After the $500 Tier 2 and Tier3 Prescription Drug Deductible has been satisfied, $40 copayment for each prescription and/or refill for a maximum thirty (30) day supply. • **Tier 3 Prescription Drugs:** After the $500 Tier 2 and Tier3 Prescription Drug Deductible has been satisfied, $60 copayment for each prescription and/or refill for a maximum thirty (30) day supply • **Tier 3 Specialty Prescription Drugs:** After the $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. **Tier 3 includes Specialty Prescription Drugs.*** ***Specialty Prescription Drugs** 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. **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.** **Tier 2 and Tier 3 Prescription Drug Deductible** Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of $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. **Note:** • Copayments for the Tier 2 and Tier 3 deductible **will not** 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. • The Tier 2 and Tier 3 Drug Deductible **will not** accumulate to satisfy the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum. **Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum:** There is a $2,500 Tier 3 Specialty Out-of-Pocket Maximum for specialty prescription drugs per member per calendar year when purchased from participating pharmacies (preferred specialty pharmacies). You will not be required to pay more than $2,500 per calendar year for specialty prescription drugs purchased from participating pharmacies (preferred specialty pharmacies). Once the $2,500 Tier 3 Out-of-Pocket Maximum is met, no further copayments or coinsurance will be required for covered specialty prescriptions obtained from participating pharmacies (preferred specialty pharmacies), for the remainder of that calendar year. **Note:** • Copayments for Tier 1 and Tier 2 drugs **will not** 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. • The Tier 2 and 3 Prescription Drug Deductible does not accumulate to satisfy the Tier 3 Specialty Prescription Drug Out-of-Pocket Maximum. • The Tier 3 Specialty 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. **Mail Order:** • **Tier 1 Prescription Drugs:** $45 copayment for each prescription and/or refill for each ninety (90) day supply. • **Tier 2 Prescription Drugs:** After a $500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $120 copayment for each prescription and/or refill for each ninety (90) day supply. • **Tier 3 Prescription Drugs:** After a $500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $180 copayment for each prescription and/or refill for each ninety (90) day supply • **Tier 3 Specialty Prescription Drugs:** After a $500 Tier 2 and Tier 3 Prescription Drug Deductible is satisfied, 25% coinsurance for each prescription and/or refill up to a maximum thirty (30) day supply. **Note:** Specialty Drugs are limited to a thirty (30) day supply.

Prescription Drugs (continued)	**Out-of-Network (Retail or Mail-Order) Pharmacy:** Please see the Member Benefits section in your Certificate for information on how to file a claim from an out-of-network pharmacy. • **Tier 1 Prescription Drugs:** ○ $15 copayment, **plus** 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. ○ $45 copayment **plus** 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. • **Tier 2 Prescription Drugs:** ○ After the $500 Tier 2 and Tier3 Prescription Drug Deductible has been satisfied, $40 copayment, **plus** 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. ○ After a $500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $120 copayment **plus** 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. • **Tier 3 Prescription Drugs:** ○ After the $500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, $60 copayment, **plus** 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. ○ After a $500 Tier 2 and Tier 3 Prescription Drug Deductible is satisfied, $180 copayment **plus** 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. • **Tier 3 Specialty Prescription Drugs:** ○ After the $500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, 25% coinsurance, **plus** 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. **Note:** Specialty Drugs are limited to a thirty (30) day supply. **Non-Formulary Prescription Drugs:** Charges for non-formulary prescription drugs will not be applied towards the Prescription Drug Deductible or the Tier 2 and Tier 3 Out-of-Pocket Maximum. • 100% of the contracted amount if purchased from a participating pharmacy. • 100% of the cash price if purchased from a non-participating pharmacy. 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 Premier 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.

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Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.
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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, acupuncture, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization (BEST), colonics or iridology.
- Artificial conception.
- Autism — This coverage does not cover any services for autism.
- 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, except as specifically stated in the certificate, 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 Illness.
- Surgery for treatment of morbid obesity
- Immunizations for travel.
- Anthem will pay a maximum of $300 per year per member for preventive care services; does not apply to pap smear, PSA and mammography.
- 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 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).
  - Anthem will cover up to forty (40) visits per calendar year for outpatient services.
- 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.

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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