

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



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

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

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

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

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

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



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

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

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

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

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

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

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

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

Coverage for medical treatment is limited to:

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

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

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

Coverage for self-management of diabetes, including:

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

**Medically Necessary**

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

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

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

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

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

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

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

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

In all other situations the maximum benefit allowance does apply.

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

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

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

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

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

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

### **Maximum Benefits**

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

### **Limitations and Exclusions**

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

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

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

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

Therapies for learning deficiencies and/or behavioral problems.

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

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

**Rate determinations**

Individual policies:

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

**Policy Renewal Provisions**

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

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

**Provider Directories**

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

**Provider Network**

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

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

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