

Summary of Benefits

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

	In-Network		Out-of-Network	
<p>Medical Deductible Applicable only to specified services (Not combined for In-Network and Out-of-Network) Hospital copayments will not apply towards the deductible.</p>	<p>Individual: \$750, \$1,500, \$2,500, \$3,500, \$5,000, \$7,500, \$10,000, \$15,000, \$25,000</p>	<p>Family Maximum: \$1,500, \$3,000, \$5,000, \$7,000, \$10,000, \$15,000, \$20,000, \$30,000, \$50,000</p>	<p>Individual: \$750, \$1,500, \$2,500, \$3,500, \$5,000, \$7,500, \$10,000, \$15,000, \$25,000</p>	<p>Family Maximum: \$1,500, \$3,000, \$5,000, \$7,000, \$10,000, \$15,000, \$20,000, \$30,000, \$50,000</p>
	<p>Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.</p>		<p>Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.</p>	
<p>Out-of-Pocket Annual Maximum The Out-of-Pocket Annual Maximum includes the deductible but is not combined for in- and out-of-network. Hospital copayments will not apply towards the out-of-pocket annual maximum, and will continue to be required after the out-of-pocket annual maximum has been met.</p>	<p>Individual: \$4,250, \$5,000, \$6,000, \$7,000, \$8,500, \$11,000, \$10,000, \$15,000, \$25,000</p>	<p>Family: \$8,500, \$10,000, \$12,000, \$14,000, \$17,000, \$22,000, \$20,000, \$30,000, \$50,000</p>	<p>Individual: \$8,500, \$10,000, \$10,000, \$11,000, \$12,500, \$15,000, \$10,000, \$15,000, \$25,000</p>	<p>Family: \$17,000, \$20,000, \$20,000, \$22,000, \$25,000, \$30,000, \$20,000, \$30,000, \$50,000</p>
	<p>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.</p>		<p>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.</p>	

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Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
<p>Physician Visits Inpatient/Outpatient For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p> <p>Office Visit For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p> <p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p> <p>50% coinsurance 0% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Services covered as part of an office visit include:</p> <ul style="list-style-type: none"> • History (gathering of information on an illness or injury) • Examination • Medical decision making (the physician's actual diagnosis and treatment plan) <p>All other covered professional services, including, but not limited to laboratory, X-ray, radiology and pathology services are subject to applicable deductible, coinsurance, or cost sharing. Please see the Professional Services section of the certificate for a full description of covered professional services.</p>
<p>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:</p> <ol style="list-style-type: none"> 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"> • 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. 	<p>Many In-Network preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member. That means Anthem pays 100% of the Allowed Charge.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p> <p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Professional services are services provided during a physician office-based visit, include, but are not limited to laboratory, X-ray, radiology and pathology services.</p> <p>Please see the Professional Services section of the certificate for a full description of covered preventive care services.</p>

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
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) For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, 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 For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, 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	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
<p>Hospital Care a) Inpatient For \$750, \$1,500, \$2,500 plans:</p> <p>For \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p> <p>b) Outpatient Surgery, Outpatient Non-emergency and Ambulatory Surgery Center For \$750, \$1,500, \$2,500 plans:</p> <p>For \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>\$500 inpatient hospital copayment per day up to three (3) days per admission, plus 50% coinsurance after deductible.</p> <p>50% coinsurance No coinsurance after deductible.</p> <p>\$200 outpatient hospital copayment per visit, plus 50% coinsurance after deductible.</p> <p>50% coinsurance No coinsurance after deductible.</p>	<p>\$500 inpatient hospital copayment per day up to three (3) days per admission, plus 50% coinsurance after deductible, and all charges in excess of the maximum benefit allowance.</p> <p>50% coinsurance 30% coinsurance after deductible plus all charges in excess of the maximum benefit allowance.</p> <p>\$200 outpatient hospital copayment per visit, plus 50% coinsurance after deductible, and all charges in excess of the maximum benefit allowance.</p> <p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Hospital copayments will not apply towards the deductible or out-of-pocket annual maximum, and will continue to be required after the out-of-pocket annual maximum has been met.</p>
<p>Emergency Care For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible.</p>	
<p>Ambulance Services Ground Services/Air Services</p> <p>In the event of a medical emergency For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p> <p>Other than in a medical emergency For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p> <p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible.</p> <p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Benefits are paid for medically necessary ground or air ambulance transportation.</p>

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
<p>Alcohol and Drug Abuse For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	
<p>Severe Mental Illness (Severe mental illnesses are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder)</p> <p>a) Inpatient For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p> <p>b) Outpatient For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p> <p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p> <p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Anthem will cover up to forty (40) inpatient days, or eighty (80) partial days (combined); excluding visits for management of medications.</p> <p>Anthem will cover up to forty (40) visits per calendar year for outpatient services; excluding visits for the management of medications.</p>
<p>Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Wigs are covered up to a maximum Anthem payment of \$500 per member per calendar year combined in and out-of-network, with a doctor's prescription. Footwear is limited to a \$400 maximum Anthem payment per calendar year, in- and out-of-network combined.</p>
<p>Home Health Care For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	<p>Benefits are limited to thirty (30) visits per member per calendar year, in- and out-of-network combined.</p>
<p>Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:</p>	<p>50% coinsurance No coinsurance after deductible.</p>	<p>50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.</p>	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Skilled Nursing Facility For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, 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 For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Human Organ and Tissue Transplant Services For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance No coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	See certificate for details on covered transplants.
Temporomandibular Joint Syndrome (TMJ) For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	
Enteral Formula and Special Foods For \$750, \$1,500, \$2,500, \$3,500, \$5,000 and \$7,500 plans: For \$10,000, \$15,000 and \$25,000 plans:	50% coinsurance No coinsurance after deductible.	50% coinsurance 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Prescription Drugs	<p>These benefits apply only to prescription drugs listed on Anthem's Plan Formulary. Members will pay 100% of the allowed amount for Drugs not shown on the Formulary.</p> <p>Participating Retail Pharmacy:</p> <ul style="list-style-type: none"> • 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 \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied, \$35 copayment for each prescription and/or refill for a maximum thirty (30) day supply. • Tier 3 Prescription Drugs: 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. Tier 3 includes Specialty Prescription Drugs.* <p>*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.</p> <p>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.</p> <p>Tier 2 and Tier 3 Prescription drug Deductible 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>Note:</p> <ul style="list-style-type: none"> • 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. 		
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:	<p>Inpatient Services: Hospital (medical and surgical care) and Hospice Care services are subject to preauthorization.</p> <p>Outpatient Services: Outpatient surgeries in a Hospital are subject to preauthorization.</p>		

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

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

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

Coverage for treatment as part of a clinical trial:

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

Coverage for medical treatment is limited to:

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

Coverage for the management and treatment of diabetes

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

Coverage for self-management of diabetes, including:

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

Medically Necessary

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

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

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

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

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

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

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

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

In all other situations the maximum benefit allowance does apply.

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

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

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

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

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

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

Maximum Benefits

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

Limitations and Exclusions

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

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

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

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

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

Rate determinations

Individual policies:

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

Policy Renewal Provisions

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

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

Provider Directories

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

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):
