Nevada Individual SmartSense Generic Rx 7500
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 amount the covered person will pay.

Medical Deductible Applicable only to specified services (Not combined for In-Network and Out-of-Network)	In-Network: Individual: $7,500 Family Maximum: $15,000 Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.	Out-of-Network: Individual: $7,500 Family Maximum: $15,000 Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.
Out-of-Pocket Annual Maximum The Out-of-Pocket Annual Maximum includes the deductible but is not combined for in- and out-of-network.	In-Network Individual: $10,000 Family: $20,000 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.	Out-of-Network Individual: $17,500 Family: $35,000 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, 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.
Lifetime Maximum Benefits: $7,000,000 per member.		

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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. 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.
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.	
Preventive Care A. Children - age-appropriate visits and routine immunizations	$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.	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. Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.
B. Adults - pap smear - mammography - cervical cancer screening - prostate screening - colorectal cancer screening	$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.	
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, speech 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.	
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.	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Emergency Care	30% coinsurance	30% coinsurance plus all charges in excess of the maximum benefit allowance.	
Ambulance Services Ground Services/Air Services	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Benefits are paid for medically necessary ground or air ambulance transportation. Ground Services; Anthem will pay a maximum of $3,000 per calendar year, in– and out-of-network combined.
Alcohol and Drug Abuse	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Detoxification: Anthem will cover no less than $1,500 per calendar year for treatment of detoxification from Alcohol or Drug Abuse. Inpatient rehabilitation: Anthem will cover benefits up to a maximum of twenty (20) days per calendar year for inpatient rehabilitation for treatment for of Alcohol or Drug Abuse. The maximum benefit will not be less than $9,000 per calendar year. Counseling: Anthem will pay benefits up to twenty (20) outpatient visits or $2500, which ever is greater, per calendar year for alcohol and drug abuse treatment.
Mental Health Care & Severe Mental Health Conditions (Severe mental health conditions 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 no less than 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 no less than 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 no less than forty (40) visits 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 no less than 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.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Anthem will pay a maximum of $5,000 per calendar year, in- and out-of-network combined. 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. Wigs are not subject to the $5,000 maximum Anthem payment for supplies, equipment and appliances. Footwear for diabetics is limited to a $400 maximum Anthem payment per calendar year; in- and out-of-network combined. Footwear is not subject to the $5,000 maximum Anthem payment for supplies, equipment and appliances.
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.
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 one hundred (100) 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.	Anthem will pay up to a $10,000 lifetime maximum benefit per member; in- and out-of-network combined.
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.	Benefits are paid up to a $4,000 lifetime maximum.
Enteral Formula and Special Foods	30% coinsurance	50% coinsurance plus all charges in excess of the maximum benefit allowance.	Anthem will pay a maximum of $2,500 per calendar year for special food products that are prescribed or ordered by a physician as medically necessary.
Generic Prescription Drugs	Participating Retail Pharmacy: • Generic Drugs: $15 copayment or 40% coinsurance, whichever is greater, for each prescription and/or refill for a maximum thirty (30) day supply. • Self-Administered Injectable Drugs: 40% coinsurance for each prescription and/or refill for a maximum thirty (30) day supply. Mail Order: • Generic Drugs: $15 copayment or 40% coinsurance, whichever is greater, for each prescription and/or refill for each thirty (30) day supply, or a $45 copayment or 40% coinsurance, whichever is greater, for up to a maximum ninety (90) day supply. • Generic Self-Administered Injectable Drugs: 40% coinsurance for each prescription and/or refill for each thirty (30) day supply, or a $45 copayment or 40% coinsurance, whichever is greater, for up to a maximum thirty (30) day supply retail or up to a ninety (90) day supply for mail-order. Out-of-Network (Retail or Mail-Order) Pharmacy: Generic Drugs: $15 Copayment or 40% coinsurance, whichever is greater, for each prescription and/or refill for each thirty (30) day supply, or a $45 copayment or 40% coinsurance, whichever is greater, for up to a maximum thirty (30) day supply retail, or up to ninety (90) day supply for mail-order. You will also be responsible for the difference between the cash price and the allowed charge.		

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Generic Prescription Drugs (continued)	Coverage is available for brand-name drugs under the following circumstances only: • Member pays 100% Coinsurance for each prescription and/or refill but will receive Anthem-negotiated savings when purchased from an in-network retail pharmacy for a maximum thirty (30) day supply retail, or up to a ninety (90) day supply for mail-order. • When required by law, Members may obtain brand–name drugs when there is no generic equivalent available. Member share of cost will be a $15 Copayment or 40% coinsurance, whichever is greater, for each prescription and/or refill for a maximum thirty (30) day supply retail, or a $45 copayment or 40% coinsurance up to a ninety (90) day supply for mail order. For your convenience, more information about these medications can be accessed on line at www.anthemprescription.com, or by contacting Customer Service at (888) 231-5046. 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 employee's unmarried dependent child becomes age 19, or 24 if financially dependent upon the subscriber.
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 preferred providers or the maximum benefit allowance for non-preferred 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 Generic 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.

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

Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the insured, or
- Serious jeopardy to the health of an unborn child, or
- Serious impairment to bodily functions, or
- Serious and permanent dysfunction of any bodily organ or part.

Maximum Benefits

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

Limitations and Exclusions

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

- Alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, message therapy, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization (BEST), clonics or iridology.
- Artificial conception.
- Services received before the effective date of coverage.
- Biofeedback.
- Blood, blood plasma and blood derivatives replaced through donor credit.
- Chelating agents, except for providing treatment for heavy metal poisoning.
- Services or supplies provided as part of clinical research, except where required by law or allowed by Anthem.
- Complications from non-covered services.
- Convalescent care.
- Convenience, luxury, deluxe services or equipment. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).
- Cosmetic services.
- Court ordered services unless those services are otherwise covered under the certificate.
- Custodial care.
- Dental services except for accident related dental services, dental anesthesia for children, temporomandibular joint therapy or surgery.
- Inpatient care received after the date Anthem, using managed care guidelines, determines discharge is appropriate.
- Domiciliary care such as care provided in a residential, non-treatment institution, halfway house or school.
- Experimental/Investigative procedures.
- Genetic testing or counseling.
- Government operated facility such as a military medical facility or veterans administration facility, unless authorized by Anthem.
- Hearing aids or routine hearing tests.
- Hypnosis, whether for medical or anesthesia purposes.
- This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation.
- Services or supplies for the treatment of intractable pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

- Therapies for learning deficiencies and/or behavioral problems.
- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to a keep scheduled appointment.
- Neuropsychiatric testing.
- Non-covered providers who include, but are not limited to:
  - Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
  - School infirmary.
  - Halfway house.
  - Massage therapist.
  - Nursing home.
  - Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Non-medical expenses, including but not limited to:
  - Adoption expenses.
  - Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
  - Vocational training services and supplies.
  - Mailing and/or shipping and handling expenses.
  - Interest expenses and delinquent payment fees.
  - Modifications to home, vehicle, or workplace regardless of medical condition or disability.
  - Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
  - 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.
- 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 - expenses resulting from pre-existing conditions are not paid until the coverage has been in effect for 12 consecutive months.
- Services related to normal pregnancy including prenatal and deliver services.
- 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
- 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 services except as provided in the Certificate.
- Services and supplies for a work- related accident or illness.
- A maximum payment of $2,500 per calendar year for special food products that are prescribed or ordered by a physician as medically necessary is allowed.

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;
- Fraud or intentional misrepresentation of material fact;
- 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):

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