Agent Guide to Individual and Family Health, Dental and Life Insurance Plans

Nevada

Anthem Blue 5000

Anthem Blue Saver 2000

Anthem Blue HSA 2600

Anthem Blue PPO Dental Plan

Individual Term Life Insurance

Anthem

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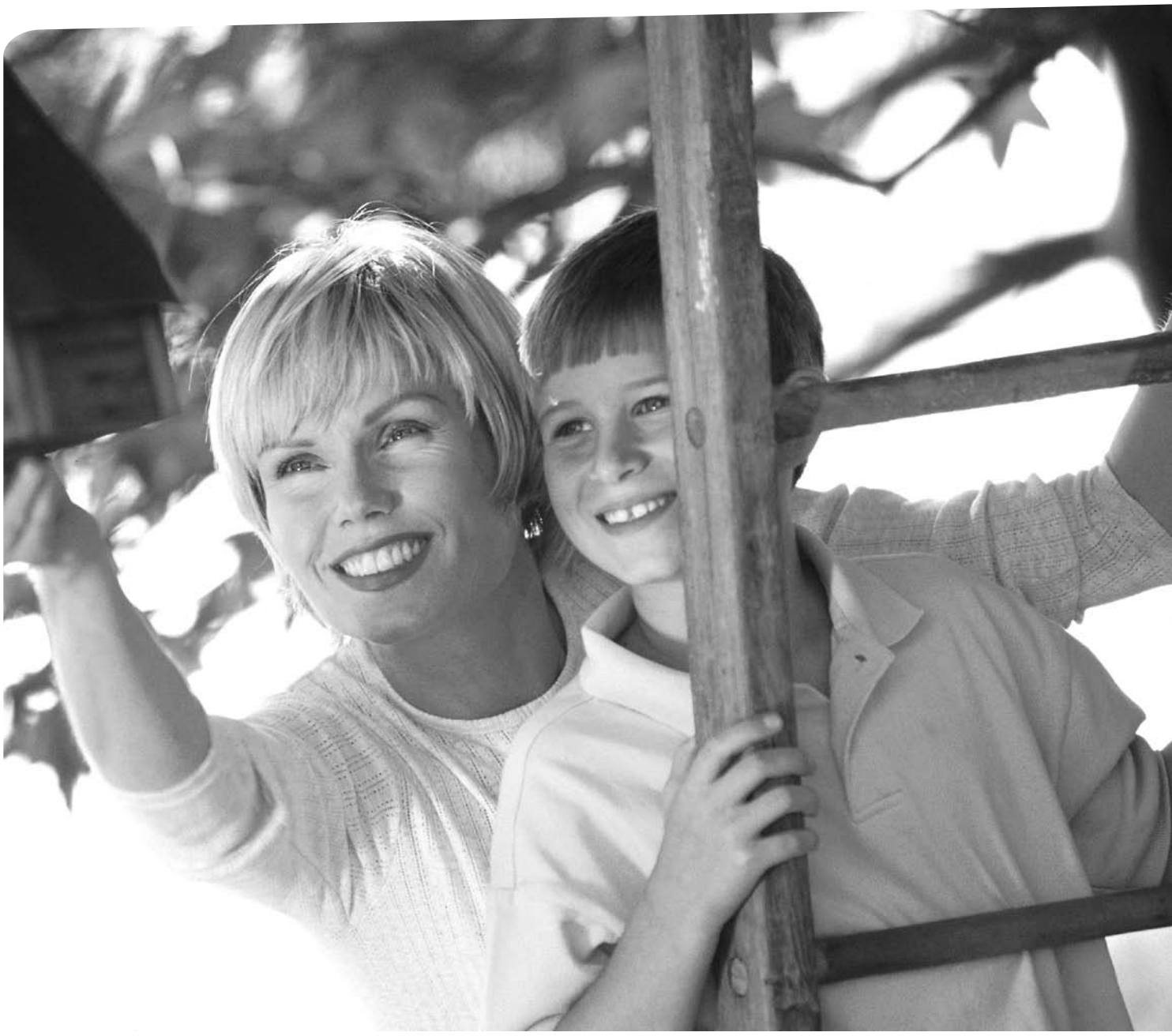
Security from a Name You Can Count On

Anthem Blue Cross and Blue Shield is pleased to offer Anthem Blue, a portfolio of PPO health care benefits plans for individuals and families in Nevada. Dental and life insurance plans also are available to your Individual clients in Nevada. Now they'll have a wider variety of Individual plans to choose from, all designed to offer affordable, flexible benefits.

Anthem Blue Plans at a Glance

The **Anthem Blue 5000** plan is typically best for healthy families who expect few health care expenses or who are mainly interested in coverage for routine care. It includes coverage for office visits; preventive care for adults; babies and children; lab work and X-rays; and more. This plan has a higher deductible with a low monthly premium.



The **Anthem Blue Saver 2000** plan is for individuals and families interested primarily in hospital coverage and reduced outpatient benefits. It has a lower deductible and monthly premium.

The **Anthem Blue HSA 2600** plan is also for individuals and families who expect few health care expenses or are mainly interested in coverage for routine care. Anthem Blue HSA 2600 is a high-deductible health plan that meets federal guidelines for your clients who want to establish a health savings account to save for future qualified medical expenses.

Please refer to the Individual and Family Health Insurance Plan Comparison matrixes on pages 4 and 5 for more details about Anthem Blue 5000, Anthem Blue Saver 2000 and Anthem Blue HSA 2600 plans.

One of the State's Largest Provider Networks

Anthem Blue plans utilize a network of nearly 3,200 health care providers and 21 hospitals throughout Nevada. Members can save money by using our network of independently contracted doctors and medical facilities. When members use in-network providers, they receive benefits at a higher level, which means lower out-of-pocket costs.

BlueCard® Access for Protection Anytime, Anywhere

Our BlueCard program gives members access to doctors and hospitals almost everywhere in the United States and in certain locations outside the country, within the plan and benefit limitations of their policy. It's a real plus for members who travel or who have eligible family members temporarily living out of state.

Prescription Mail-order Program

Members whose health plan includes benefits for prescription drugs can take advantage of our mail-order program if they take a prescription drug regularly. They save time and money by ordering up to a 60-day supply by mail.

Online Programs for a Personal Path Toward Wellness

Members can log on to anthem.com to take advantage of our many online capabilities:

- **MyAnthem**™. This secure online portal lets members to view benefit information, check claims status, order a replacement health plan ID card and more.
- **MyHealth@Anthem®**. This online resource offers information to help members make better and smarter health care choices.
- **SpecialOffers@Anthem**℠. This discount program offers savings of up to 50 percent on many health-related products and services, such as weight-loss programs, eyeglasses, hearing aids and cosmetic dentistry.
- **The Healthcare Advisor®**. This hospital comparison tool helps members find easy-to-understand information about a health condition or recommended procedure, as well as learn how hospitals in their area measure up in experience and results of care.
- **The PharmaAdvisor**™. This tool helps members research the drug options available for common conditions, view drug interactions, and compare and evaluate alternatives.

Anthem Blue 5000 and Anthem Blue Saver 2000 Individual and Family Health Plan Comparison*

All plans feature a $5,000,000 per member lifetime benefit maximum.

This matrix is intended to help you compare Anthem Blue plan benefits and reflects Anthem Blue Cross and Blue Shield's share of costs for covered expenses after any deductibles are met. When a member uses in-network providers, benefits are paid based on Anthem's negotiated rate, which may often result in savings for the member. When a member uses out-of-network providers, benefits are paid based on charges Anthem determines to be reasonable for that service and area. Reasonable charges may be less than a provider's billed charges and often result in higher out-of-pocket costs for the member.

All plans with deductibles feature a fourth-quarter carry-over for the annual calendar-year deductible. If a member's annual deductible isn't satisfied in a given year, the covered expenses incurred during the months of October through December and applied to the annual deductible for that year will be applied toward the annual deductible for the following year.

*This is only a summary of the health care plans. Please refer to each Summary of Coverage and policy for complete coverage information.

[1]Services may require preauthorization by Anthem Blue Cross and Blue Shield. If preauthorization isn't obtained, the member may incur a penalty.

[2]Emergency room visits that don't result in an inpatient admission will be subject to a $60 penalty.

[3]Certain prescription drugs may require preauthorization.

Amounts shown below are Anthem Blue Cross and Blue Shield's share of covered expenses after any applicable deductibles are met, except where noted.

	Anthem Blue 5000		Anthem Blue Saver 2000	
Plan Features	**In-network Providers**	**Out-of-network Providers**	**In-network Providers**	**Out-of-network Providers**
Annual Deductible per Member	$5,000 with a two-member family maximum		$2,000 with a two-member family maximum	
Annual Out-of-pocket Maximums	$3,500 plus deductible per member, $7,000 plus deductible per family	$7,000 plus deductible per member, $14,000 plus deductible per family	$3,500 plus deductible per member, $7,000 plus deductible per family	$7,000 plus deductible per member, $14,000 plus deductible per family
Lifetime Maximum	$5,000,000 per member		$5,000,000 per member	
Office Visits	First four office visits per member per year: Anthem waives the deductible (member pays a $30 copayment); 5+ office visits per member per year: Anthem pays 70%, subject to deductible	50%	Two office visits per member per year, in-network and out-of-network combined: Anthem waives the deductible (member pays a $30 copayment); 3+ office visits: Member pays 100% of billed charges	Two office visits per member per year, in-network and out-of-network combined: Anthem pays 50% (deductible waived); 3+ office visits: Member pays 100% of billed charges
Professional Services Surgery, anesthesia, radiation therapy and in-hospital doctor visits	70%	50%	70% for inpatient only	50% for inpatient only
Preventive Care for Babies and Children (through age 6) Examinations and lab tests	For office visits only, see office visits above; for any lab work or X-rays, see below		Not covered	
Immunizations	70%	50%	Not covered	
Adult Preventive Care Routine Pap tests, and annual mammograms, colorectal cancer screenings and PSA screenings	70%	50%	70% (deductible waived)	50% (deductible waived)
Lab Work and X-rays	70%	50%	70% with a maximum payment of $300 per member per year (deductible waived); in-network and out-of-network combined	50% with a maximum payment of $300 per member per year (deductible waived); in-network and out-of-network combined
Inpatient Hospital Services[1]	70%	50% less a $500 deductible for non-mergency stays	70%	50% less a $500 deductible for non-emergency stays
Outpatient Medical Care[2]	70%	50%	70%	50%
Physical/Occupational Therapy and Acupuncture/Acupressure	$30 maximum per visit, with a combined maximum of 12 visits per year		Not covered	
Ambulatory Surgical Center[1]	70%	50%	70%	50%
Ambulance Service With a maximum covered expense per trip of $750	70%	50%	70%	50%
Durable Medical Equipment	70%	50%	Not covered	
Initial Care for a Medical Emergency Inpatient or outpatient	70%	70%	70%	70%
Annual Brand-name Prescription Drug Deductible Retail pharmacy	$500 per member		$200 per member	
Prescription Drugs[3] Retail pharmacy Per prescription (up to a 30-day supply)	**Generic drugs:** 100% after member pays $10 copayment **Brand-name drugs:** 100% after member pays $25 copayment	**Generic drugs:** 50% of the average wholesale price **Brand-name drugs:** 40% of the average wholesale price	$500 maximum per member per year. Includes generic and brand-name drugs, in-network and out-of-network retail and mail service combined. **Generic drugs:** 100% after member pays $10 copayment **Brand-name drugs:** 100% after member pays $25 copayment	$500 maximum per member per year. Includes generic and brand-name drugs, in-network and out-of-network retail and mail service combined. **Generic drugs:** 50% of the average wholesale price **Brand-name drugs:** 40% of the average wholesale price
Mail Service Per prescription (up to a 60-day supply)	**Generic drugs:** 100% after member pays $20 copayment **Brand-name drugs:** 100% after member pays $50 copayment	Not available	**Generic drugs:** 100% after member pays $20 copayment **Brand-name drugs:** 100% after member pays $50 copayment	Not available

Anthem Blue HSA 2600 Individual and Family Health Plan Comparison*

Features a $5,000,000 per member lifetime benefit maximum.

This matrix is intended to show you the Anthem Blue HSA 2600 plan benefits and reflects Anthem Blue Cross and Blue Shield's payment for covered expenses after the annual and out-of-network deductibles are met. When a member uses in-network providers, benefits are paid based on Anthem's negotiated rate, which may often result in savings for the member.

When a member uses out-of-network providers, benefits are paid based on charges Anthem determines to be reasonable for that service and area. Reasonable charges may be less than a provider's billed charges and often result in higher out-of-pocket costs for the member.

*This is only a summary of the health care plan. Please refer to the Summary of Coverage and policy for complete coverage information.

[1]This deductible applies to covered expenses incurred for services received from out-of-network providers after the annual deductible is met.

[2]Services may require preauthorization by Anthem Blue Cross and Blue Shield. If preauthorization isn't obtained, the member may incur a penalty.

[3]Emergency room visits that don't result in an inpatient admission will be subject to a $60 penalty.

[4]Certain prescription drugs may require preauthorization.

Amounts shown below are Anthem Blue Cross and Blue Shield's share of covered expenses after any applicable deductibles are met.

Plan Features	Anthem Blue HSA 2600			
	Individual		Family	
	In-network Providers	Out-of-network Providers	In-network Providers	Out-of-network Providers
Lifetime Maximum	$5,000,000 per member		$5,000,000 per member	
Annual Deductible	$2,600		$5,200	
		Additional $4,000 out-of-network deductible[1]		Additional $8,000 out-of-network deductible[1]
Annual Out-of-pocket Maximums (includes annual deductible, copayments and coinsurance amounts the member may pay to pharmacy and other providers)	$5,000	$10,000	$10,000	$20,000
Professional Services Office visits, surgery, anesthesia, radiation therapy, in-hospital doctor visits and diagnostic lab work and X-rays	80%	50%	80%	50%
Preventive Care for Babies and Children (through age 6) Exams, immunizations and lab tests	80%	50%	80%	50%
Adult Preventive Care Routine Pap tests and annual mammograms, colorectal cancer screenings and PSA screenings	80%	50%	80%	50%
Inpatient Hospital Services[2]	80%	50%	80%	50%
Outpatient Medical Care[3]	80%	50%	80%	50%
Physical/Occupational Therapy and Acupuncture/Acupressure	$30 maximum per visit, with a combined maximum of 12 visits per year		$30 maximum per visit, with a combined maximum of 12 visits per year	
Ambulatory Surgical Center[2]	80%	50%	80%	50%
Ambulance Service With a maximum covered expense per trip of $1,000 for ground and $5,000 for air	80%	50%	80%	50%
Durable Medical Equipment	80%	50%	80%	50%
Initial Care for a Medical Emergency Inpatient or outpatient	80%	80%	80%	80%
Prescription Drugs[4] Deductibles apply **Retail Pharmacy** Per prescription (up to a 30-day supply)	**Generic drugs:** 100% after member pays $10 copayment **Brand-name formulary drugs:** 100% after member pays $30 copayment **Brand-name non-formulary drugs:** 100% after member pays $50 copayment	**Generic and brand-name drugs:** 50% of the average wholesale price	**Generic drugs:** 100% after member pays $10 copayment **Brand-name formulary drugs:** 100% after member pays $30 copayment **Brand-name non-formulary drugs:** 100% after member pays $50 copayment	**Generic and brand-name drugs:** 50% of the average wholesale price
Mail Service Per prescription (up to a 60-day supply)	**Generic drugs:** 100% after member pays $20 copayment **Brand-name formulary drugs:** 100% after member pays $60 copayment **Brand-name non-formulary drugs:** 100% after member pays $100 copayment	Not available	**Generic drugs:** 100% after member pays $20 copayment **Brand-name formulary drugs:** 100% after member pays $60 copayment **Brand-name non-formulary drugs:** 100% after member pays $100 copayment	Not available

Individual Term Life Insurance

For just pennies per day*, your clients can enjoy security and peace of mind by knowing they can meet their family's financial needs even if they're not there to provide for them.

Here are some great reasons for adding life insurance coverage to an Anthem Blue health care plan:

- Life insurance provides a financial safeguard for members' families.
- There are no additional forms to complete.
- There are no medical exams.
- All life plans are available with Anthem Blue health plans.
- Members can buy life insurance for all eligible family members.
- Your clients can choose from five benefit amount options — $15,000, $25,000, $50,000, $75,000 or $100,000 — for most age groups.

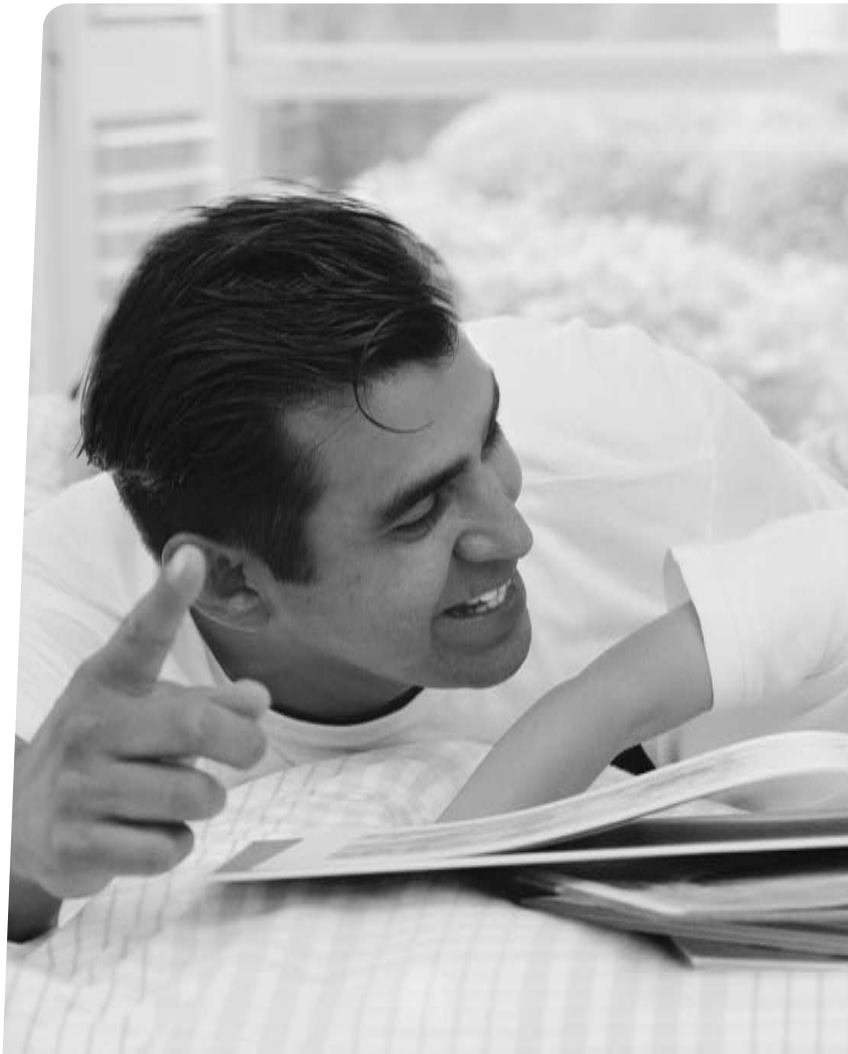
To apply for coverage, your clients simply complete the Term Life portion in section 4 on the individual enrollment application.

*The rates for term life insurance will vary based on the applicant's age. The policy is issued for a one-year term, renewable at the policyholder's option. The rate schedule may change at the beginning of any annual term. Rates are subject to change without notice. Please contact your Anthem Blue Cross and Blue Shield regional sales manager for the most current rates.

Term life insurance coverage is subject to the written provisions of the policy issued by Anthem Life Insurance Company. Each family member who elects the term life insurance option will be sent a separate policy.

The policy will be canceled automatically on the first day of the month of the policyholder's 65th birthday. If that birthday falls on the first of the month, the policy will be cancelled on the first day of the month before the birth month.

Life insurance products are underwritten by Anthem Life Insurance Company.



Anthem Blue PPO Dental Plan for Individual and Families

Anthem Blue Cross and Blue Shield now offers an affordable plan that provides coverage for regular dental care. With our Anthem Blue PPO Dental Plan, members have:

- Access to quality dental care at discounted rates.
- A wide range of dental services to meet their needs.
- No waiting period for preventive and diagnostic care.
- The freedom to choose any dentist.
- A yearly $50 deductible per person with a maximum of three deductibles per family.

Additional Savings with In-network Dentists

Choosing an in-network dentist means receiving care at our negotiated discounted rates. Members can choose from a network of nearly 400 dental providers in Nevada. The plan still provides benefits if members choose an out-of-network dentist, but their out-of-pocket expenses may be higher. Members are responsible for any charges their out-of-network dentist bills that exceed the stated benefit amount.

Members in counties with limited network access can visit in-network dentists outside their local area and still receive coverage at the in-network negotiated rates. Benefits are still available for out-of-network dentists, as specified by the plan.

Eligibility

Individuals and their dependents must be Nevada residents. Eligible dependents include:

- Lawful spouses, 64½ years old or younger.
- Any unmarried child or stepchild of the member or the member's enrolled spouse who is under age 19.
- Any unmarried child or stepchild who is a full-time student (at least 12 units per semester) who is under age 24.

Dental Benefit Schedules

These dental benefit schedules show a brief overview of benefits available to members. Anthem Blue Cross and Blue Shield pays either the specified amount or the actual amount charged by the provider, whichever is lower. The member is responsible for any charges exceeding the stated benefit amount.

Preventive and Diagnostic Care[1] *Coverage begins on the policy effective date.*		
Procedure	**Anthem Pays**	
	In-network Dentist	Out-of-network Dentist
Periodic oral exam; limited to 2 per member per year	100%	$15
Bitewing X-rays (1 film[2])	100%	$9
Bitewing X-rays (2 films[2])	100%	$14
Single (periapical) X-rays (first film[2])	100%	$9
Single X-rays (additional films[2])	100%	$9
Bitewing X-rays (4 films[2])	100%	$21
Full mouth X-rays, limited to 1 set every 3 years[2]	100%	$38
Routine cleaning, limited to 2 per adult per year[3]	100%	$40
Routine cleaning, limited to 2 per child per year[4]	100%	$26
Cleaning with fluoride, limited to 2 per child per year[4]	100%	$36
Topical fluoride only, limited to 2 per child per year[4]	100%	$12

Basic Dental Care[1] *Coverage begins after the plan has been in effect for six continuous months.*	
Procedure	**Anthem Pays**
	In-network and Out-of-network Dentists
Filling (1 surface/2 surfaces/3 surfaces/4 or more surfaces)	$42 / $54 / $65 / $78
Extraction (erupted tooth or root)	$39
Surgical removal of erupted tooth	$72
Removal of impacted tooth (soft tissue/partial bony/complete bony)	$100 / $120 / $150

Major Dental Care[1] *Coverage begins after the plan has been in effect for 12 continuous months.*	
Procedure	**Anthem Pays**
	In-network and Out-of-network Dentists
Scaling/root planing per quadrant	$43
Gingivectomy (1 to 3 teeth per quadrant/4 or more contiguous teeth per quadrant)	$30 / $97
Root canal (1 canal/2 canals/3 canals)	$127 / $155 / $205
Crown (porcelain fused to high noble metal)	$225
Stainless steel crown	$55
Pontic (porcelain fused to high noble metal)	$225
Partial/complete denture (upper or lower)	$275 / $300
Denture reline (chairside/lab)	$55 / $80

[1] All dental benefits are limited to a maximum payment of $1,000 for expenses incurred by each enrolled member during a calendar year.
[2] Total benefit for single and bitewing X-rays, not to exceed the cost of full mouth X-rays ($38)
[3] Adult: Any person or dependent 19 years of age or older covered by the Anthem Blue PPO Dental Plan
[4] Child: Any person or dependent 18 years of age or younger covered by the Anthem Blue PPO Dental Plan
These schedules only provide a brief description of certain features of the plan. This is not the insurance contract, and only the actual policy provisions will apply. The policy sets forth in more detail the benefits, limitations and exclusions. If there are any conflicts between the terms of the policy and the information in this brochure, the terms of the policy will prevail.

Important Additional Information

Balanced Risk Keeps Costs Down

We maintain risk balance by underwriting applicants using a rate-up structure of level 1, level 1+20, level 1+25, level 1+50 and level 1+75. That means we can accept more of your clients who have certain conditions or who take certain medications, when they're willing to pay a higher premium.

We still may have to decline coverage for some of your clients, but those who we do accept will be fully covered for their conditions, with no waivers. However, they may be subject to pre-existing waiting periods. This includes prescription drug coverage for those plans with prescription drug benefits.

Terms of Coverage

- Coverage under Anthem Blue Cross and Blue Shield's Anthem Blue plans remains in force as long as the member pays premiums on time and remains eligible for coverage.
- Coverage stops when the member becomes ineligible due to divorce or a change in dependent status. In the case of divorce or over-age dependents, we'll offer the member a similar plan.
- Rates are age-banded. If a member or a covered dependent moves into a new age bracket that results in a higher rate category, we'll adjust the rate beginning with the premium for the month of January following the person's birthday.
- We can change plan premiums with 60 days' advance written notice to the member. Anthem won't change the premium schedule for Anthem Blue plans on an individual basis, but only for all members in the same class and covered by the same plan.

30-day FREE Look

Members have 30 full days to examine and either accept or decline coverage by returning their policy.

Facts About Anthem Blue Plans

Pre-existing Conditions

Anthem Blue Cross and Blue Shield won't provide coverage for the 12 months following the effective date of the member's plan for health conditions that existed in the six months before the effective date.

Utilization Management

We use a process called utilization management to help members receive coverage for appropriate treatment in the correct setting and to help members avoid unexpected out-of-pocket costs and unnecessary procedures.

Preauthorization

Preauthorization assesses benefit eligibility before services are provided. All inpatient health care services require preauthorization.

Otherwise, the member will be subject to a $500 penalty per continuing hospital confinement. Preauthorization should be initiated at least three working days before admission to a licensed and accredited hospital or ambulatory surgical center. Failure to obtain preauthorization may result in additional penalties as outlined in the member's policy.

All surgical services at an ambulatory surgical center require preauthorization or the member will be subject to a $50 penalty as outlined in the member's policy. Preauthorization is required for certain other services for the member to be eligible for maximum benefits. Benefits are reduced by 50 percent for the following services unless Anthem provides preauthorization: organ/tissue transplants, infusion therapy, home health services, skilled nursing facility services and hospice care.

Utilization review is the benefit coverage evaluation of medical necessity, efficiency, and/or appropriateness of services and treatments. Other services also require preauthorization to be eligible for maximum benefits. Members' policies will include more details about preauthorization, additional deductibles, covered services, and limitations and exclusions.

Please note: Penalties explained above aren't counted toward any annual deductible or out-of-pocket maximum.

Health Plan Enrollment Guidelines

Eligibility for Anthem Blue 5000 and Anthem Blue Saver 2000

To be eligible for enrollment, an applicant must be:

- Age 64½ or younger; or
- The applicant's spouse, age 64½ or younger; or
- The applicant's unmarried child or stepchild who hasn't yet reached age 19; or
- The applicant's unmarried child who is a full-time student (at least 12 units per semester), under age 24 and financially dependent for at least half of their support; and
- A resident of the United States for at least six months; and
- Able to meet Anthem Blue Cross and Blue Shield's underwriting requirements; and
- Ineligible for Medicare.

Eligibility for Anthem Blue HSA 2600

To be eligible for enrollment, an applicant must be:

- Age 65 or younger;* or
- The applicant's spouse, age 65 or younger;* or
- The applicant's unmarried child or stepchild who has not yet reached age 19; or
- An unmarried child or stepchild who is a full-time student (at least 12 units per semester), under 24 years of age and who is financially dependent on the applicant; and
- A resident of the United States for at least six months; and
- Able to meet Anthem Blue Cross and Blue Shield's underwriting guidelines; and
- Ineligible for Medicare; and
- Not enrolled in any other Group or Individual health insurance plan.

Eligibility for a Health Savings Account (HSA)

To be eligible to establish an HSA, an applicant must:

- Be covered under an HSA-qualified high-deductible health plan; and
- Not be covered by any other health plan;** and
- Not be entitled to Medicare benefits (generally, this means the applicant is under age 65); and
- Not be eligible to be claimed as a dependent on another person's tax return.

*While children can apply for Anthem Blue Cross and Blue Shield's high-deductible health plan (children-only plan), children aren't eligible to establish an HSA in their name.

**It is permitted to have insurance under which substantially all the coverage provided relates to workers' compensation laws, tort liabilities, liabilities related to ownership of property (e.g., automobile insurance), insurance for a specified disease or illness, insurance that pays a fixed amount per day (or other period) of hospitalization, coverage for accidents, coverage for disability, dental care, vision care or long-term care and still be eligible for an HSA.

Health Plan Limitations and Exclusions

The primary limitations and exclusions for the plans described in this plan overview are listed below. This listing is an overview only. A more detailed list of each plan's limitations and exclusions can be found in the applicable policy. Only the actual terms of the applicable policy will apply.

Limitations

The following primary limitations apply to the **Anthem Blue 5000** and **Anthem Blue Saver 2000** plans:

Infusion Therapy: Covered expenses will not exceed: total parenteral nutrition (with or without lipids), $250 per day; antibiotics, average wholesale price (AWP) + $125 per day; chemotherapy, AWP + $150 per day, pain management, $125 per day; aerosol therapy, AWP + $70 per day; tocolytic therapy, $250 per day; special items, AWP; intravenous hydration, $75 per day.

Ambulance Service: Limited to a maximum covered expense of $750 per trip for air or ground transport.

Home Health: Limited to a combined maximum of 60 visits each year.

Skilled Nursing Facilities: Limited to a maximum covered expense of $400 per day and 100 days per year.

Services for Mental, Emotional or Functional Nervous Disorders:

- **Inpatient:** Eligible inpatient hospital services are paid up to $100 per day, up to a maximum payment of $3,000 per year.
- **Outpatient:** Eligible treatment is payable up to $30 per visit, up to a maximum of 12 visits per year, for inpatient or outpatient professional charges.

Severe Mental Illness: Benefits are provided for a maximum of 40 days' hospitalization as an inpatient per year and for a maximum of 40 visits to an outpatient facility per year.

Alcohol and Drug Abuse: Limited to a maximum payment per year of up to $9,000 for inpatient services, $2,500 for counseling and $1,500 for withdrawal treatment.

Hospice: Limited to a lifetime maximum payment of $10,000.

Smoking Cessation: Benefits for any smoking cessation program are payable up to a maximum of $50 per lifetime.

Additional Limitations for the Anthem Blue 5000 Plan

Physical, Occupational Therapy/Medicine and Acupuncture/Acupressure: Benefits are payable up to $30 per visit with a combined maximum of 12 visits per year.

Additional Limitations for the Anthem Blue Saver 2000 Plan

Office Visits: Limited to two visits per member per year for in-network and out-of-network providers combined.

Lab Work and X-rays (non-hospital based): Limited to a maximum payment of $300 per member per year, with deductible waived, in-network and out-of-network providers combined.

Prescription Drug Maximum Benefit: Limited to a maximum payment of $500 per member per year. Includes generic and brand-name, in-network and out-of-network retail and mail order combined.

Exclusions

The **Anthem Blue 5000** and **Anthem Blue Saver 2000** plans do not provide benefits for:

- Any amounts exceeding the maximum amounts of covered services stated in the policy.
- Services not specifically listed in the policy as covered services.
- Services or supplies that are not medically necessary as defined by Anthem Blue Cross and Blue Shield.
- Services or supplies that are experimental or investigational except as specifically stated under the "Clinical Trials" section in the policy.
- Services received before the effective date of coverage or during an inpatient stay that began before that effective date.
- Services received after coverage ends.
- Services for which the member has no legal obligation to pay or for which the member wouldn't be charged if the member did not have a health plan or insurance coverage.
- Any condition covered by workers' compensation or similar laws.

Health Plan Limitations and Exclusions *(continued)*

- Any intentionally self-inflicted injury or illness.
- Services received for any condition caused by, or contributed by, an act of war or the inadvertent release of nuclear energy when government funds are available for treatment.
- Any services for which payment may be obtained from, or provided by, any local, state or federal government agency, except when payment under the policy is expressly required by federal or state law. Veterans Administration hospitals and military treatment facilities will be considered for payment according to current legislation.
- Any services for which Medicare benefits have been paid.
- Professional services received from a person who lives in the member's home or who is related to the member by blood, marriage or adoption.
- Services of a private duty nurse.
- Custodial care or inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- Dental services, except as specifically stated in the policy.
- Orthodontic services, braces and other orthodontic appliances.
- Dental implants or any associated procedures.
- Hearing aids.
- Routine hearing tests, except as provided under well-baby and well-child care.
- Optometric services, except as specifically stated in the policy.
- Certain eye surgeries, including those solely for the purpose of correcting refractive defects.
- Outpatient speech therapy.
- Any drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the policy.
- Cosmetic surgery or other services for beautification. This exclusion does not apply to medically necessary reconstructive surgery to restore a bodily function, to correct a deformity caused by injury or congenital defect of a newborn child, or to restore symmetry incident to a mastectomy.
- Sex-change operations or related treatment and study.
- All services related to the evaluation or treatment of fertility and/or infertility.
- Non-prescription contraceptive drugs, devices and supplies, and non-FDA approved prescription contraceptive drugs, devices and supplies.
- Services primarily for weight reduction or treatment of obesity (including morbid obesity).
- Routine physical exams or tests, except as specifically stated in the policy.
- Charges by a provider for telephone consultations.
- Items primarily for the member's personal comfort or convenience.
- Educational services, except as specifically provided or arranged by Anthem Blue Cross and Blue Shield.
- Nutritional counseling or food supplements.
- Any services received on or within 12 months after the effective date of coverage if they are related to a pre-existing condition.
- Charges for pregnancy or any condition related to pregnancy, except for complications of pregnancy.
- Growth hormone treatment.

Additional Exclusions for the Anthem Blue Saver 2000 Plan

- Any services of a physician, except as specifically stated under limited professional and other services.
- Acupuncture/acupressure.
- Durable medical equipment.
- Physical and/or occupational therapy/medicine or chiropractic services, except when provided during an inpatient hospital confinement.
- Outpatient professional services for mental, emotional or functional nervous disorders.
- Charges for a smoking cessation program.
- Surgical procedures for sterilization.

Health Plan Limitations and Exclusions *(continued)*

The following primary limitations apply to the **Anthem Blue HSA 2600 plan:**

Infusion Therapy: Covered expenses will not exceed: total parenteral nutrition (with or without lipids), $250 per day; antibiotics, average wholesale price (AWP)+$125 per day; chemotherapy, AWP + $150 per day, pain management, $125 per day; aerosol therapy, AWP + $70 per day; tocolytic therapy, $250 per day; special items, AWP; intravenous hydration, $75 per day.

Ambulance Service: A maximum covered expense of $5,000 per trip for air transport or $1,000 per trip for ground transport.

Home Health Care: Limited to a combined maximum of 60 visits each year.

Skilled Nursing Facilities: Limited to a maximum covered expense of $400 per day and 100 days per year.

Services for Mental, Emotional or Functional Nervous Disorders (other than Severe Mental Illness): Benefits for eligible treatment are payable up to $30 per visit up to a maximum of 12 visits per year for inpatient or outpatient professional charges. Benefits for eligible inpatient hospital services are paid up to $100 per day, up to a maximum payment of $3,000 per year.

Services for Severe Mental Illness: Benefits for eligible treatment are limited to a combined maximum of 40 days per year for inpatient hospital charges and 40 days per year for inpatient or outpatient professional charges.

Physical, Occupational Therapy/Medicine and Acupuncture/Acupressure: Benefits are payable up to $30 per visit with a combined maximum of 12 visits per year.

Hospice: Limited to a lifetime maximum payment of $10,000.

Smoking Cessation: Benefits for any smoking cessation program designed to end the dependency on nicotine are payable up to a maximum of $50 per lifetime.

Services for Alcohol and Drug Dependence:

- For the treatment of withdrawal, acute inpatient hospital charges and professional charges are limited to a combined maximum payment of $1,500 per year.
- For continued care, inpatient hospital charges are limited to a maximum payment of $9,000 per year; and inpatient or outpatient continued care professional charges are limited to a maximum payment of $2,500 per year.

Inherited Metabolic Disease: Special food products are limited to a maximum covered expense of $2,500 per year.

Exclusions

The **Anthem Blue HSA 2600** plan does not provide benefits for:

- Services for any condition for which benefits are excluded by a waiver.
- Experimental: any medical, surgical and/or other procedure, service, product, drug or device (including implants) whose use is mainly limited to laboratory and/or animal research. Anthem Blue Cross and Blue Shield has the sole discretion to make this determination.
- Investigational: any medical, surgical and/or other procedure, service, product, drug or device (including implants), that: (a) does not have final approval from the appropriate governmental regulatory body; or (b) is not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or (c) does not improve the health outcome of the patient treated; or (d) is not as beneficial as any established alternative; or (e) results outside the investigational setting cannot be demonstrated or duplicated; or (f) is not generally approved or used by physicians in the medical community. Anthem Blue Cross and Blue Shield has the sole discretion to make this determination.
- Any amounts exceeding the maximum amounts for covered services stated in the policy.
- Services not specifically listed in this policy as covered services.
- Services or supplies that are not medically necessary as defined by Anthem Blue Cross and Blue Shield.
- Services received before the effective date of coverage or during an inpatient stay that began before that effective date.

Health Plan Limitations and Exclusions *(continued)*

- Services received after coverage ends.
- Services for which the member has no legal obligation to pay or for which the member wouldn't be charged if the member did not have a health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability or occupational disease law, even if the member doesn't claim those benefits.
- Any intentionally self-inflicted injury or illness.
- Conditions caused by or resulting from: (a) an act of war; (b) the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy; (c) an insured person participating in the military service of any country; (d) an insured person participating in an insurrection, rebellion or riot; (e) services received as a direct result of an insured person's commission of, or attempt to commit a felony or as a direct result of the insured person being engaged in an illegal occupation; or (f) an insured person, being under the influence of illegal narcotics or non-prescribed controlled substances unless administered on the advice of a physician.
- Any services provided by a local, state or federal government agency, except when payment under this policy is expressly required by federal or state laws.
- Any services covered by Medicare under Part A or Part B if the member is eligible for Medicare.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration hospitals and military treatment facilities will be considered for payment according to current legislation.
- Professional services received or supplies purchased from the member, a person who lives in the member's home or who is related to the member by blood, marriage or adoption, or the member's employer.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain; custodial care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Dental services.
- Orthodontic services.
- Dental implants: dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- Hearing aids.
- Routine hearing tests, except as provided under well-baby and well-child care.
- Optometric services; eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams; and routine eye refractions.
- Eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient speech therapy.
- Any drugs, medications or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a physician
- Cosmetic surgery or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to reconstructive surgery to restore a bodily function or to correct a deformity caused by injury or congenital defect of a newborn child, or for medically necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.

Health Plan Limitations and Exclusions *(continued)*

- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction, impotence and/or inadequacy.
- All services related to the evaluation or treatment of fertility and/or infertility and drugs used for the primary purpose of treating infertility or promoting fertility.
- All non-prescription contraceptive drugs, devices and/or supplies that are available over the counter or without a prescription, and non-FDA approved prescription contraceptive drugs, devices and/or supplies. FDA-approved prescription contraceptive drug**s** or devices available through a licensed pharmacy are covered under the plan's prescription drug benefit.
- Charges for normal pregnancy or maternity care, including normal delivery, elective abortions and elective non-emergency cesarean sections, as long as the service is not related to complications of pregnancy.
- Cryopreservation of sperm or eggs.
- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
- Services primarily for weight reduction or treatment of obesity, including morbid obesity, or any care that involves weight reduction as a main method for treatment.
- Routine physical exams or tests, including those required by employment or government authority.
- Charges by a provider for telephone consultations.
- Items furnished primarily for the member's personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for hygiene or beautification, including wigs, etc.).
- Educational services.
- Nutritional counseling or food supplements, except for special food products necessary for the treatment of certain inherited metabolic diseases. (See Limitations.)
- Any services received on or within 12 months after the effective date of coverage if they are related to a pre-existing condition.
- Growth hormone treatment.
- Routine foot care, including the cutting or removal of corns or calluses, the trimming of nails, routine hygienic care, and any service rendered in the absence of localized illness, injury or symptoms involving the feet.
- Charges for which Anthem Blue Cross and Blue Shield is unable to determine its liability because the member failed, within 60 days, or as soon as reasonably possible to (a) authorize Anthem to receive all the medical records and information requested or, (b) provide Anthem with information requested about the circumstances of a claim.
- Charges for animal to human organ transplants.
- Drugs and medications not requiring a prescription, except insulin.
- Dietary supplements, cosmetics, and health or beauty aids.
- Drugs used for cosmetic purposes.
- Drugs obtained outside the United States.
- Drugs for treatment of a condition, illness or injury for which benefits are excluded or limited by a waiver, pre-existing condition or other contract limitation.
- Drugs and medications used to induce non-spontaneous abortions.
- Non-medical substances or items.
- Anorexiants or drugs associated with weight loss.
- Any vitamin, mineral, herb or botanical product that does not have an FDA- (Food and Drug Administration) approved indication to treat, diagnose or cure a medical condition even if it is thought to have health benefits.
- Any expense incurred that exceeds Anthem Blue Cross and Blue Shield's negotiated rate. In-network providers agree to accept the negotiated rate as payment in full for covered services.
- Any drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications.
- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent.
- Lost or stolen prescriptions.

Dental Plan Limitations and Exclusions

The primary limitations and exclusions for the Anthem Blue PPO Dental Plan described in this brochure are listed below. This listing is an overview only. A more detailed list of the plan's limitations and exclusions can be found in the policy.

Limitations

The following primary limitations apply to the **Anthem Blue PPO Dental Plan:**

Prosthodontics: Replacement of a fixed or removable prosthesis if such replacement occurs within five years of the original placement, unless the denture is a stayplate used during the healing period for recently extracted anterior teeth.

Adjustment, repairs or relines to a prosthesis, except following six months after the initial placement and if the prosthesis was paid for under this plan.

Fixed bridges, removable cast partials and/or cast crown with or without veneers for patients under 16 years of age.

Replacement of crowns and cast restorations, including porcelain crowns, if such replacement occurs within five years of the original placement.

Prosthodontics and Periodontics: Services for fixed or removable prosthodontics within the first 12 months of the member's effective date.

Services for periodontics within the first 12 months of the member's effective date.

Diagnostic: Oral examinations exceeding two visits per member per year.

More than one set of full-mouth X-rays or its equivalent per member in a three-year period.

Preventive: Prophylaxis treatments exceeding two treatments per member per year.

Fluoride applications for patients over 18 years of age or applications exceeding two visits per year.

Exclusions

The **Anthem Blue PPO Dental Plan** does not provide benefits for:

- Any amounts exceeding the maximum amount stated in the yearly maximum benefit section of the policy or listed in the benefit schedule.
- Services or supplies Anthem Blue Cross and Blue Shield considers to be not medically necessary or experimental or investigational.
- Services received before the coverage effective date or after coverage ends.
- Services for which the member wouldn't be charged if the member didn't have insurance coverage or services for which the member is not legally obligated to pay.
- Any condition for which benefits could be recovered either by adjudication, settlement or otherwise under any workers' compensation, employer's liability or occupational disease law, even if the member doesn't claim those benefits.
- Disease contracted or injuries sustained as a result of declared or undeclared war and/or conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Any services provided by a local, state, county or federal government agency, including any foreign government.
- Professional services received from a person who lives in the member's home or who is related to the member by blood, marriage or adoption.

Dental Plan Limitations and Exclusions *(continued)*

- Any services performed for cosmetic purposes, unless they are for the correction of functional disorders or as a result of an accidental injury occurring while the member was covered under this policy.
- Charges for treatment by a person other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.
- Replacement of an existing prosthesis that has been lost, stolen, or which, in the opinion of a dentist, is or can be made satisfactory.
- Orthodontic services, braces, appliances and all related services.
- Diagnosis or treatment of the joint of the jaw and/or occlusion services, supplies or appliances provided in connection with:
  - Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint).
  - Any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion).
  - Treatment to change vertical dimension (the space between the upper and lower jaw).
- Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions.
- Correction of congenital or developmental malformation.
- If a member transfers from the care of one dentist to that of another dentist during the course of treatment or if more than one dentist provides services for one dental procedure, Anthem Blue Cross and Blue Shield will only be responsible for the amount it would have been responsible for if one dentist provided the services.
- Prescribed drugs, premedication or analgesia.
- Oral hygiene instruction.
- Services for treatment of malignancies.
- All hospital costs and any additional fees charged by the dentist for hospital treatment.
- Implants (materials implanted into or on bone or soft tissue) or the removal of implants.
- Replacement of teeth missing before the coverage effective date.

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