Anthem Blue Cross and Blue Shield/HMO Nevada
Benefit Summary Disclosure Information
700 Broadway, Denver, CO 80273
877-833-5734

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

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). It does mean that as to the diagnosis or treatment of the member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.
- 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.

Maximum allowed amount

Reimbursement for services rendered by in-network and out-of-network providers is based on this health benefits plan maximum allowed amount for the covered service that the member receives.

NOTE: Anthem will apply the in network level of benefits and the member will not be required to pay more for the services than if the services had been received from a participating provider in the following circumstances:

- Emergency care (where rendered either within or outside the State of Nevada)
- Where in-patient hospital care at a non-participating hospital is necessary due to the nature of the treatment
- Where in-patient hospital care at a non-participating hospital is necessary due to participating provider hospital capacity
- When a member has received a preauthorized network exception

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 member, 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 you 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. Following are examples of the plan's limitations and exclusions (please consult your *Schedule of Benefits* and the booklet for an exhaustive listing of exclusions and limitations):

- Benefits provided under any local, state, or federal laws, including Workers' Compensation and Medicare
- Cosmetic surgery
- Services by a family member
- Weight-reduction services and medications
- Complications from non-covered services
- Most services, such as non-emergency hospital admissions or surgical procedures require prior authorization.

- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), clonics or iridology.
- Services received before the effective date of coverage.
- Biofeedback.
- 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.
- 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).
- Court ordered services unless those services are otherwise covered under the booklet.
- 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.
- Hospital care if the member leaves a hospital against the medical advice of the physician, charges which are a direct result of the member's knowing and voluntary non-compliance of medically necessary care with prescribed medical treatment are not eligible for coverage.
- Domiciliary care such as care provided in residential, non-treatment institution, halfway house or school.
- Services and supplies already covered by other valid coverage.
- Experimental/Investigative procedures.
- Genetic counseling.
- Government operated facility such as a military medical facility or veterans administration facility unless authorized by Anthem.
- Hair loss, drugs, wigs, hairpieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a physician prescription, and a medical reason for the hair loss.
- 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 which they are convicted of.
- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to keep a 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.
- 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.

- 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 or professional courtesy or discount.
- 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, services, supplies or medications related to a sex change operation.
- Treatment of sexual dysfunction or impotence including all services, supplies or prescription drugs used for the treatment.
- Services and supplies which may be reimbursed by a third party
- 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.
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.
- Whole blood, blood plasma and blood derivatives received from community sources or replaced through donor credit.
- Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Rate determinations

Rates are calculated based on allowable characteristics of member age, geographic rating area, dependent enrollment, and tobacco use.

Policy Renewal Provisions

Small Group policies – This coverage is renewable at the option of the plan sponsor, except for the following reasons:

- Non-payment of the required premium;
- Fraud or intentional misrepresentation of material fact;
- Fails to comply with participation or contribution rules;
- The carrier decides to discontinue offering coverage under group insurance in Nevada.

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