

BluePreferred for Individuals

Nevada Health Plan Description Form

This summary provides you with the deductible, coinsurance, and a brief description of your benefits. For more complete information, see your Membership Certificate or call Customer Service at 1-800-992-6907.

DEDUCTIBLE applicable only to specified services (Per calendar year, aggregate deductible for family)

500-30-80/50 **In-Network:** Individual: \$500.00, Family: \$1,500.00; **Out-of-Network:** Individual: \$1,000.00, Family: \$3,000.00
500-35-50/50 **In-Network:** Individual: \$500.00, Family: \$1,500.00; **Out-of-Network:** Individual: \$1,000.00, Family: \$3,000.00
1000-35-80/50 **In-Network:** Individual: \$1,000.00, Family: \$3,000.00; **Out-of-Network:** Individual: \$2,000.00, Family: \$6,000.00
2000-40-70/50 **In-Network:** Individual: \$2,000.00, Family: \$6,000.00; **Out-of-Network:** Individual: \$4,000.00, Family: \$12,000.00
3000-70/50 **In-Network:** Individual: \$3,000.00, Family: \$9,000.00; **Out-of-Network:** Individual: \$6,000.00, Family: \$18,000.00

Services	In-Network after Deductible		Out-of-Network after Deductible		Additional Information
	Ground Services	Air Services	Ground Services	Air Services	
Ambulance Services 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	80%	80%	80%	80%	Benefits are paid for medically necessary ground or air ambulance transportation. Ground Services are limited to a maximum benefit of \$500 per trip. Air Services are limited to a maximum benefit of \$5,000 per trip.
Alcohol and Drug Abuse 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	Inpatient	Outpatient	Inpatient	Outpatient	Benefits are paid for medically necessary treatment for detoxification up to \$1,500; inpatient or outpatient rehabilitation \$9,000; and counseling \$2,500 per member per calendar year.
	80%	80%	50%	50%	
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
	80%		50%		
Emergency Care * 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					
	80%		50%		

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Services	In-Network after Deductible		Out-of-Network after Deductible		Additional Information
Home Health Care 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					Benefits are limited to 60 visits per calendar year.
Hospice Care 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					Benefit period of three months up to maximum of two additional benefit periods, subject to a \$5,000 payment limit per benefit period, payable at \$55 per day.
Hospital Care Inpatient/Outpatient Surgery and Outpatient Nonemergency 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					
Maternity Care 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	Inpatient	Outpatient	Inpatient	Outpatient	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
	80%	\$30 copay per visit	50%	50%	
	50%	\$35 copay per visit	50%	50%	
	80%	\$35 copay per visit	50%	50%	
	70%	\$40 copay per visit	50%	50%	
	70%	70%	50%	50%	
Severe Mental Illness 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	Inpatient	Outpatient	Inpatient	Outpatient	Benefits are paid up to 40 inpatient days, 80 partial days (combined). Benefits are paid up to 40 visits per calendar year.
	70%	70%	50%	50%	
	50%	50%	50%	50%	
	70%	70%	50%	50%	
	70%	70%	50%	50%	
	70%	70%	50%	50%	
Physical Rehabilitation (physical, occupational, and speech therapy) Inpatient and Outpatient 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					Benefits are paid up to 45 days per year. Benefits are paid up to 12 visits for physical therapy, 12 visits for occupational therapy and 12 visits for speech therapy per calendar year.

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Physician Visits			
500-30-80/50 Inpatient Outpatient Outpatient – urgent	80% \$30 copayment per visit \$60 copayment per visit	50% 50% 50%	
500-35-50/50 Inpatient Outpatient Outpatient – urgent	50% \$35 copayment per visit \$70 copayment per visit	50% 50% 50%	
1000-35-80/50 Inpatient Outpatient Outpatient – urgent	80% \$35 copayment per visit \$70 copayment per visit	50% 50% 50%	
2000-40-70/50 Inpatient Outpatient Outpatient – urgent	70% \$40 copayment per visit \$80 copayment per visit	50% 50% 50%	
3000-70/50 Inpatient Outpatient Outpatient – urgent	70% 70% 70%	50% 50% 50%	
Preventive Care			
500-30-80/50 A. Children - routine child exam to age 13 - immunizations to age 13 B. Adults - routine pap smear - routine mammography - routine prostate screening	80% not subject to deductible 80% not subject to deductible \$75 maximum payment for laboratory charges \$85 maximum payment \$65 maximum payment	50% 50% \$85 maximum payment \$65 maximum payment	Annual pap smears for women 18 years or older. One screening mammogram for women between 35 and 40; and annual mammogram for women over 40 years of age. One yearly prostate screening for men 50 years of age and older, and in high-risk men 40 years of age and older. All maximum payments are combined from Preferred and Non-Preferred providers.
500-35-50/50 A. Children - routine child exam to age 13 - immunizations to age 13 B. Adults - routine pap smear - routine mammography - routine prostate screening	50% not subject to deductible 50% not subject to deductible \$75 maximum payment for laboratory charges \$85 maximum payment \$65 maximum payment	50% 50% \$85 maximum payment \$65 maximum payment	
1000-35-80/50 A. Children - routine child exam to age 13 - immunizations to age 13 B. Adults - routine pap smear - routine mammography - routine prostate screening	80% not subject to deductible 80% not subject to deductible \$75 maximum payment for laboratory charges \$85 maximum payment \$65 maximum payment	50% 50% \$85 maximum payment \$65 maximum payment	

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
2000-40-70/50 A. Children - routine child exam to age 13 - immunizations to age 13 B. Adults - routine pap smear - routine mammography routine prostate screening	70% not subject to deductible 70% not subject to deductible \$75 maximum payment for laboratory charges \$85 maximum payment \$65 maximum payment	50% 50% \$85 maximum payment \$65 maximum payment	
3000-70/50 A. Children - routine child exam to age 13 - immunizations to age 13 B. Adults - routine pap smear - routine mammography routine prostate screening	70% not subject to deductible 70% not subject to deductible \$75 maximum payment for laboratory charges \$85 maximum payment \$65 maximum payment	50% 50% \$85 maximum payment \$65 maximum payment	
Spinal Manipulations 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	80% 50% 80% 70% 70%	50% 50% 50% 50% 50%	Benefits are limited to a maximum payment of \$200 per calendar year per member.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	80% 50% 80% 70% 70%	50% 50% 50% 50% 50%	
Temporomandibular Joint Syndrome (TMJ) 500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	50% 50% 50% 50% 50%	50% 50% 50% 50% 50%	Benefits are paid up to a \$4,000 lifetime 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, and the services are received within six months of the injury.
OUTPATIENT PRESCRIPTION DRUGS:	500-30-80/50: Participating Retail Pharmacy: Generic \$15 copayment; Brand Formulary \$40 copayment; Non-Formulary \$60 copayment (up to a 34-day supply). Mail order: Generic \$30 copayment; Brand Formulary \$80 copayment; Non-Formulary \$120 copayment (up to a 90-day supply). 500-35-50/50: Not covered except for medication, equipment, supplies and appliances that are medically necessary for the treatment of diabetes type I, type II, and gestational diabetes subject to the Non-Preferred deductible and coinsurance. 1000-35-80/50: Participating Retail Pharmacy: Generic \$15 copayment; Brand Formulary \$40 copayment; Non-Formulary \$60 copayment (up to a 34-day supply). Mail order: Generic \$30 copayment; Brand Formulary \$80 copayment; Non-Formulary \$120 copayment (up to a 90-day supply). 2000-40-70/50: Participating Retail Pharmacy: Generic \$15 copayment; Brand Formulary \$40 copayment; Non-Formulary \$60 copayment (up to a 34-day supply). Mail order: Generic \$30 copayment; Brand Formulary \$80 copayment; Non-Formulary \$120 copayment (up to a 90-day supply).

	3000-70/50: Participating Retail Pharmacy: Generic \$15 copayment; Brand Formulary \$40 copayment; Non-Formulary \$60 copayment (up to a 34-day supply). Mail order: Generic \$30 copayment; Brand Formulary \$80 copayment; Non-Formulary \$120 copayment (up to a 90-day supply).	
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.	
PRECERTIFICATION PRIOR AUTHORIZATION PENALTIES:	Inpatient Services: Hospital (medical and surgical care), Hospice Care services are subject to Pre-certification. If pre-certification is not obtained prior to receiving services, we reduce our payment allowance to 50% of what otherwise would have been paid for all services related to the inpatient admission. If you have met the Maximum Out-of-Pocket Expense amount, the payment allowance will be reduced to 70% of what otherwise would have been paid.	Outpatient Services: Outpatient surgeries in a Hospital or Other Facility are subject to Pre-certification. If pre-certification is not obtained prior to receiving services, we will reduce our payment allowance to 50% of what otherwise would have been paid for all services related to the surgery. If you have met the Maximum Out-of-Pocket Expense amount, the payment allowance will be reduced to 70% of what otherwise would have been paid.
MAXIMUM OUT-OF-POCKET EXPENSE AMOUNT: (Does not apply to TMJ care)	Preferred Providers: 500-30-80/50: Individual: You pay 20 percent of the Allowable Charge up to \$3,000 plus deductible and copayments. Family: You pay 20 percent of the Allowable Charge up to \$6,000 plus deductible and copayments. 500-35-50/50: Individual: You pay 50 percent of the Allowable Charge up to \$2,500 plus deductible and copayments. Family: You pay 50 percent of the Allowable Charge up to \$5,000 plus deductible and copayments. 1000-35-80/50: Individual: You pay 20 percent of the Allowable Charge up to \$3,000 plus deductible and copayments. Family: You pay 20 percent of the Allowable Charge up to \$6,000 plus deductible and copayments. 2000-40-70/50: Individual: You pay 30 percent of the Allowable Charge up to \$4,500 plus deductible and copayments. Family: You pay 30 percent of the Allowable Charge up to \$9,000 plus deductible and copayments. 3000-70/50: Individual: You pay 30 percent of the Allowable Charge up to \$4,500 plus deductible and copayments. Family: You pay 30 percent of the Allowable Charge up to \$9,000 plus deductible and copayments.	Non-Preferred Providers: 500-30-80/50: Individual: You pay 50 percent of the Allowable Charge up to \$6,000 plus deductible. Family: You pay 50 percent of the Allowable Charge up to \$12,000 plus deductible. 500-35-50/50: Individual: You pay 50 percent of the Allowable Charge up to \$5,000 plus deductible. Family: You pay 50 percent of the Allowable Charge up to \$10,000 plus deductible. 1000-35-80/50: Individual: You pay 50 percent of the Allowable Charge up to \$6,000 plus deductible. Family: You pay 50 percent of the Allowable Charge up to \$12,000 plus deductible. 2000-40-70/50: Individual: You pay 50 percent of the Allowable Charge up to \$7,500 plus deductible. Family: You pay 50 percent of the Allowable Charge up to \$15,000 plus deductible. 3000-70/50: Individual: You pay 50 percent of the Allowable Charge up to \$7,500 plus deductible. Family: You pay 50 percent of the Allowable Charge up to \$12,000 plus deductible.
LIFETIME MAXIMUM BENEFITS:	\$2,000,000 per member.	

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. Our determination of Allowable Charge is the maximum amount we approve for any particular service. Deductible, coinsurance, or other cost sharing amounts are based on this allowance and are the amounts you pay the provider.

***Emergency** – means the 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 an 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.

Medically Necessary – benefits are payable only for covered services and supplies that are medically necessary which meet the following definition:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition, and
2. Provided for the diagnosis or direct care and treatment of the medical condition, and
3. Within standards of good medical practice within the organized medical community, and
4. Not primarily for the convenience of the Member, the Member's physician or another provider, and
5. The most appropriate supply or level of services which can safely be provided. For hospital stays this means acute care as an inpatient as necessary due to the kind of services you are receiving or the severity of your condition, and that safe and adequate care cannot be received as an outpatient or in a less acute medical setting. Claims for services that are not Medically Necessary may be denied either before or after payment of such services.

ANTHEM VISION SUMMARY PLAN DESCRIPTION

This Summary Plan Description outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.

Anthem's Provider Network: Anthem Vision contracts with many providers which include independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 10,000 conveniently located providers nationwide. Members may call Anthem Vision toll-free (800) 231-2583 or visit www.anthem.com any time for provider locations. Schedule an appointment with your Anthem provider; identify yourself as an Anthem member for fast, paperless determination and confirmation of benefits.

Network Provider: Maximum benefits are achieved when members access their benefits from an *Anthem* Participating Provider. Copayment(s) may apply to in-network benefits.

Non-Network Provider Reimbursements: Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members may then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to *Anthem Vision* for reimbursement according to the Non-Network Reimbursement schedule identified in this Summary Plan Description.

Value Added Savings: Anthem Providers agree to Preferred Pricing that is significantly below retail. Members are able to achieve substantial savings on additional pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items. Members may save approximately 20% to 40% or more off retail when they visit an *Anthem* Provider.

Copayment(s): Copayment amounts are applicable to Network Provider examinations and materials. Separate copayments may be charged for examinations and materials. Materials consist of lenses and frames or contact lenses. Separate copayments for lenses and frames will not apply if these services are received at the same time.

Anthem Vision Benefits	Member Benefit from Network Provider	Non-Network Reimbursement**
<p>Vision Examination: Each member is entitled to a comprehensive vision examination by an Anthem Provider.</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p><i>Availability : Once every 12 months*</i></p>	<p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p>	<p>Up to \$35.00 Up to \$35.00 Up to \$35.00 Up to \$35.00 Up to \$35.00</p>
<p>Lenses: A choice of glass or plastic (CR39) lenses in single vision, and bifocal or trifocal (FT 25-28); lenses up to 55 mm; and all ranges of prescriptions.</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p>	<p>\$30.00 Materials copayment applies to lenses and frames \$35.00 Materials copayment applies to lenses and frames \$35.00 Materials copayment applies to lenses and frames \$40.00 Materials copayment applies to lenses and frames \$40.00 Materials copayment applies to lenses and frames</p>	
<p>Single Vision Lenses</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p>	<p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p>	<p>Up to \$25.00 Up to \$25.00 Up to \$25.00 Up to \$25.00 Up to \$25.00</p>
<p>Bifocal Lenses (pair)</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p>	<p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p>	<p>Up to \$40.00 Up to \$40.00 Up to \$40.00 Up to \$40.00 Up to \$40.00</p>

Anthem Vision Benefits	Member Benefit from Network Provider	Non-Network Reimbursement**
<p>Progressive Lenses (pair)</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p>Trifocal Lenses (pair)</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p>Lenticular</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p><i>Availability : Once every 12 months*</i></p>	<p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p> <p>Maximum Allowable Amount equal to bifocal amount. Member pays difference.</p> <p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p> <p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p>	<p>Up to \$40.00 Up to \$40.00 Up to \$40.00 Up to \$40.00 Up to \$40.00</p> <p>Up to \$55.00 Up to \$55.00 Up to \$55.00 Up to \$55.00 Up to \$55.00</p> <p>Up to \$80.00 Up to \$80.00 Up to \$80.00 Up to \$80.00 Up to \$80.00</p>
<p>Frames: Maximum Allowable Amount of \$120.00 (retail) for frames purchased from Network Provider. Member pays Preferred Price in excess of Maximum Allowable Amount.</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p><i>Availability : Once every 24 months*</i></p>	<p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p>	<p>Up to \$45.00 Up to \$45.00 Up to \$45.00 Up to \$45.00 Up to \$45.00</p>
<p>Contact Lenses***:</p> <p>Elective - Members have a \$105.00 plan allowance per benefit period toward cosmetic contact lenses <i>in lieu of the frame and lens benefits</i>. If the member chooses contact lenses greater than the plan allowance, the member is responsible for the difference.</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p>Medically Necessary</p> <p>500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50</p> <p><i>Availability : Once every 12 months*</i></p>	<p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p> <p>Plan provides 10% discount on disposable lenses and 15% on other traditional lenses.</p> <p>\$30.00 Copayment \$35.00 Copayment \$35.00 Copayment \$40.00 Copayment \$40.00 Copayment</p>	<p>Up to \$80.00 Up to \$80.00 Up to \$80.00 Up to \$80.00 Up to \$80.00</p> <p>Up to \$210.00 Up to \$210.00 Up to \$210.00 Up to \$210.00 Up to \$210.00</p>

*From your last date of service

** Non-Network Reimbursement represents Plan's allowance towards eligible benefits and may not cover all charges.

***See Membership Certificate for definitions of Elective and Medically Necessary Contact Lenses.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.

- Orthoptics or vision training and any supplemental testing; Plano (non- prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Sub-normal vision aids.
- Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses.
- Charges in excess of Usual and Customary for services and materials.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Summary Plan Description.