



Enclosed is the Blue Cross/Blue Shield application you requested. To avoid unnecessary delays in the underwriting process, please be sure to complete the application in full. The following tips may help you:

1. Read and Sign the enclosed "Health Insurance Application Disclosure Statement/Acknowledgement". This document must be included with your application to ensure prompt processing.
2. Please fill out the Enrollment Application completely and sign the application on page 3.
3. Submit your first month's premium by check or money order made payable to "**Blue Cross/Blue Shield**" or by completing the bottom section of Form 98644, "Initial Payment Only Credit Card Premium".
4. Billing: Monthly Bank Draft is the preferred mode, please complete the top section of Form 98644. Otherwise, your bill will be sent to the mailing address listed on your application.
5. You may request your effective date of coverage. As long as your application has been received by Blue Cross/Blue Shield and there is no missing or additional information required, they will honor your requested date. The normal underwriting process takes 3 to 5 weeks. If medical records are requested, the review process will be slightly longer.
6. If you choose to make your initial premium payment by credit card, the complete application and Form 98644 can be faxed to us at 702.877.0956

If you have questions, please give us a call at (702) 258-1995. Your completed application can be mailed to the address listed below or in the enclosed envelope provided.

# BluePreferred: The Affordable and Reliable

*In today's world of early retirement offers, self-employment and single parenting, the need for a reliable health plan for individuals is more critical now than ever before.*



When you are on your own, choosing a health plan takes on a whole new level of importance. Whether you are self-employed, between jobs, or have taken early retirement, the importance of securing reliable protection from high health care expenses can't be overstated. At Anthem Blue Cross and Blue Shield, we understand. And that's why we offer BluePreferred PPO for Individuals.

BluePreferred PPO for Individuals provides affordable coverage you can count on. It offers comprehensive benefits, convenience and access to one of the state's largest provider networks—all at very competitive rates. But most importantly, BluePreferred is backed by the strength, stability and security of Anthem Blue Cross and Blue Shield, one of Nevada's largest insurers and most trusted names in health care.

## *BluePreferred Benefits at a Glance*

BluePreferred provides the benefits you care most about and then some. Here is a snapshot of the coverage offered by BluePreferred:

- **Hospital care.** Hospital benefits include unlimited approved days in semiprivate room or medically necessary private room. This includes drugs, lab services and x-rays, anesthesia, oxygen and blood transfusions received during those approved days. Depending on the plan design you choose, in-network hospital care is covered at 80%, 70% or 50% after the deductible is met.
- **Physician office visits.** Non-routine office visits to network doctors are covered at 100% after a copay. (The one exception is the \$3000 deductible plan design, in which office visits are subject to the deductible and coinsurance.) Lab, x-ray and out-of-network office visits are subject to the annual deductible and coinsurance.
- **Preventive care.** Many preventive care services are covered, including well-child physician office visits, immunizations for children and health screenings such as mammograms, Pap smears and prostate cancer screenings.
- **Inpatient and outpatient surgery.** Inpatient and outpatient surgeries are covered subject to the deductible and coinsurance. This includes transplants for these major organs: lung, heart, heart-lung, pancreas, cornea, kidney and bone marrow, within certain guidelines (\$1 million maximum benefit for each type of transplant).
- **Prescriptions.** Prescriptions, including oral contraceptives and contraceptive devices, are included in most plan designs. You can have prescriptions filled at any pharmacy in the network, which includes nearly every independent or chain store pharmacy in the state. Drug copays depend on whether your prescription is filled with a generic (\$15), brand name (\$40) or non-formulary (\$60) medication. For people who require maintenance medication such as insulin, this

# Protection You Want from the Name You Trust

plan also offers the convenience of mail order prescription service. (Note: The \$500 deductible plan design with 50/50 coinsurance does not include prescription drug benefits.)

- **Emergency care and ambulance service.** In case of emergency illness or injury, BluePreferred has you covered—including ground and air ambulance travel.
- **Many “extras.”** BluePreferred PPO for Individuals covers many types of health care expenses you might not expect, including physical rehabilitation, occupational and speech therapy, dental care for accidental injuries, mental health care, home health and hospice care. It even covers second surgical opinions.

*Please refer to the Summary of Benefits Schedule or Membership Certificate for complete details on plan and benefit limitations.*



## *One of the State's Largest Provider Networks*

BluePreferred PPO for Individuals utilizes a network of nearly 3,700 health care providers and 19 hospitals throughout Nevada. When you use these providers, you'll receive a higher benefit level, which means lower out-of-pocket costs. You also won't have to submit claim forms.

If you prefer to use a non-network provider, you'll still have coverage. You'll pay a higher deductible and a greater percentage of your health care costs. But, unlike many other individual health plans, BluePreferred does offer meaningful coverage for care received from non-network providers. And, an annual out-of-pocket maximum protects you from unmanageable health care costs related to non-network services.

**A note about preauthorization:** Some services, such as non-emergency hospital admissions, surgical procedures, durable medical equipment and home health care, require prior approval, or “preauthorization” from Anthem Blue Cross and Blue Shield. Preauthorization helps provide the assurance that treatment plans are medically necessary and consistent with generally accepted medical standards.

When you use network providers, they will take care of preauthorization for you. If you use non-network providers, ensuring your doctor gets preauthorization is your responsibility.

## *Protection You Carry With You, Wherever You Go*

When you're a Blue Cross and Blue Shield plan member, your health plan ID card is your passport to health care benefits wherever you go—across the

**Enroll Today. Questions? Call Anthem at 1-800-873-2261. Or contact your insurance broker.**

# Choosing the Plan that's Right for You

When it comes to health plans, one size does *not* fit all. With BluePreferred PPO for Individuals, you're able to choose from a variety of plan designs. You determine the deductible and coinsurance levels that fit your life and your budget. The table below summarizes the differences between available plans.

## What You Pay

Understanding your financial responsibilities will help prevent unwelcome surprises. So please, take a few minutes to review these basics about your share of health care costs. If you have questions, contact our Sales Department for clarification.

### Copays

A copay is a flat dollar amount you pay for a service. You do not have to meet your deductible to take advantage of copays. Just pay your copay at the time of service, and the plan pays 100% of the rest. BluePreferred PPO for Individuals includes copays for prescription drugs and non-routine office visits (except the \$3000 deductible plan design). If an office visit includes lab or x-ray services, those expenses are subject to the deductible and coinsurance.

### Deductible

A deductible is an annual dollar amount that you must pay before BluePreferred begins to

cover most medical services. There are separate deductibles for network and non-network care. Expenses applied to your deductible are calculated when claims are processed.

### Coinsurance

Once your deductible is met, BluePreferred starts paying a percentage of eligible health care costs. Depending on the plan design you choose, BluePreferred pays 80%, 70% or 50% of charges for in-network services and 50% for non-network services. You are responsible for the remaining coinsurance, until applicable expenses reach your plan's out-of-pocket maximum.

#### **A note about non-network provider fees:**

To help control costs, Anthem Blue Cross and Blue Shield has negotiated discounts with network providers. All network providers have agreed to accept Anthem's contracted "allowable charge" as payment in full for services covered by the plan. Non-network providers may charge you more; if they do, you will be responsible for paying any amounts over Anthem's allowable charge.

### Out-of-Pocket Maximum

An out-of-pocket maximum protects you and your family from unmanageable health care costs by putting a ceiling on the total coinsurance you will pay each year. If your share

of coinsurance reaches this maximum, BluePreferred will cover 100% of eligible charges for the remainder of the benefit period. Please note that there are separate out-of-pocket maximums for network and out-of-network care.

The out-of-pocket maximum does not apply to copays. You will continue to pay your copays for office visits and prescription drugs even if you reach the out-of-pocket maximum.

### Explanation of Benefits

After each claim is processed, you and your provider will receive an Explanation of Benefits (EOB) from Anthem Blue Cross and Blue Shield. An EOB describes how benefits have been paid, helps you understand the cost of care, and illustrates the true value of your health plan.

Information on non-covered services, amounts applied toward deductibles and the status of out-of-pocket maximums are clearly detailed. Review each EOB carefully. If you ever have questions or concerns about how benefits have been paid, please call Customer Service.

BluePreferred Plan Design:	Office Visit Copay	Rx Drug Copays <sup>1</sup>	Annual Deductible <sup>2</sup> In-Network Individual/Family	Coinsurance <sup>3</sup> Plan Pays Network/Non-Network	In-Network Out-of-Pocket Maximum <sup>4</sup> Individual/Family	<i>Deductibles and Out-of-Pocket Maximums are higher for non-network services.</i>
BP 500-80/50	\$30	\$15/40/60	\$500/\$1,500	80%/50%	\$3,000/\$6,000	
BP 1,000-80/50	\$35	\$15/40/60	\$1,000/\$3,000	80%/50%	\$3,000/\$6,000	
BP 2,000-70/50	\$40	\$15/40/60	\$2,000/\$6,000	70%/50%	\$4,500/\$9,000	
BP 500-50/50	\$35	N/A	\$500/\$1,500	50%/50%	\$2,500/\$5,000	
BP 3,000-70/50	N/A	\$15/40/60	\$3,000/\$9,000	70%/50%	\$4,500/\$9,000	

1 Dollar amounts for prescription drug copays refer to generic/brandname/non-formulary drugs

2 For families of two, annual deductibles are per person (2x individual deductible); for families of three or more, family deductibles are capped at amounts shown

3 Coinsurance applies to most, but not all, covered services that are not subject to copay

4 Copays and deductibles do not apply toward annual out-of-pocket maximums

5 See the plan's Summary of Benefits Schedule or Membership Certificate for more information on non-network deductibles and out-of-pocket maximums

**SECTION I**

**Nevada Blue Preferred for Individuals  
Application For Individual/Family Enrollment**

**Broker Name:** Nevada Benefits  
**Broker Number:** 23397

**BROKER SIGNATURE:** Phil Lanzetta **DATE:** \_\_\_\_\_

**Broker Address:** 9505 Hillwood Dr. Las Vegas, NV 89134

**Broker Phone Number:** 702-258-1995 **Broker Fax Number:** 702-877-0956

**APPLICATION TYPE**  NEW ENROLLMENT  ADD FAMILY MEMBER Indicate Existing Subscriber No. \_\_\_\_\_  
(Check Appropriate box)  APPLICATION FOR REINSTATEMENT  COVERAGE CHANGE Deductible \_\_\_\_\_ Coinsurance \_\_\_\_\_ Other \_\_\_\_\_

HAVE YOU PREVIOUSLY BEEN COVERED BY ANTHEM BLUE CROSS AND BLUE SHIELD (HEREINAFTER REFERRED TO AS ANTHEM)?  YES  NO  
IF "YES," WAS THIS COVERAGE UNDER A  GROUP OR  INDIVIDUAL POLICY? (PLEASE CHECK ONE) PROVIDE CONTRACT NUMBER \_\_\_\_\_

**MONTHLY PAYMENT METHOD**  ELECTRONIC FUNDS TRANSFER (EFT) [PREFERRED METHOD] OR  PAPER BILL  
If choosing Electronic Funds Transfer, please complete the Monthly Bank Draft / EFT Authorization (Form No. 98644) and attach a voided check.

**No Application will be processed without the initial month's premium being received.**

Initial month payment method:  Check  Money Order  Credit Card  Debit Card  
**Credit / debit card accepted for initial payment only** - if paying with a credit / debit card, you must fill out the bottom section of Form No. 98644.

**COVERAGE DESIRED**  Individual  Family  
**DEDUCTIBLE SELECT ONE**  \$500 Deductible  \$2,000 Deductible  \$500 Deductible 50/50 Plan  
 \$1,000 Deductible  \$3,000 Deductible

**SECTION II FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK — PLEASE PRINT CLEARLY**

NAME (Last, First, Middle Initial)			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (Mo. Day Yr)	HEIGHT	WEIGHT
PHYSICAL STREET ADDRESS			HOME TELEPHONE ( ) ( )	WORK TELEPHONE ( ) ( )		
CITY	STATE NV	ZIP CODE	OCCUPATION	GROSS ANNUAL INCOME		

BILLING ADDRESS (if different than above)

**SOCIAL SECURITY NUMBER** \_\_\_\_\_ **NON-SMOKING DESIGNATION AND CERTIFICATION**  
I certify that I, and all family members living in the household,  HAVE  HAVE NOT used a tobacco product in the past 24 months.

**MARITAL STATUS**  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED  PROFESSIONAL  MAIDEN  OTHER—Explain \_\_\_\_\_  
IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES CHECK APPLICABLE BOX

**SPOUSE NAME, (if applying for spouse coverage) (Last, First, Middle Initial)** \_\_\_\_\_ **SOCIAL SECURITY NUMBER** \_\_\_\_\_ **SEX**  Male  Female **BIRTHDATE (Mo. Day Yr)** \_\_\_\_\_ **HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_

**CHILDREN:** Unmarried, dependent children are under family membership through the end of the month in which they reach age 19, or age 24 if financially dependent or medically certified as disabled and dependent. Please submit a completed Coverage Dependent Enrollment Request form or Mentally or Physically Disabled Dependent Enrollment Request form for all dependent children over age 19.

LAST NAME	FIRST NAME	M. I.	RELATIONSHIP	M	F	SOCIAL SECURITY NUMBER	BIRTHDATE	HEIGHT	WEIGHT
							Month Day Year		

**SECTION III REQUESTED EFFECTIVE DATE**

Requested effective date: Day: \_\_\_\_\_ of Month \_\_\_\_\_  
All monthly premium will be due on the first of each month. If you are approved for an effective date other than the first of the month, your premium will be prorated for that first month. Anthem must receive your application prior to the requested effective date. If you do not select an effective date, your application will be processed for the first of the month following Underwriting approval.

1)  
those testing positive or currently being treated for AIDS

**SECTION IV**

**HEALTH STATEMENT**

Have you or any family member listed on the application consulted, had diagnostic or other medical tests, or been treated by any doctor, health care professional, hospital, hospital emergency room, or clinic within the last five (5) years for any of the following conditions, diseases or disorders?

**(All questions must be answered.)**

CONDITION/DISEASE/DISORDER	YES	NO	CONDITION/DISEASE/DISORDER	YES	NO
Alcohol or Drug Abuse			Nervous and Mental Disorders including Anxiety, Depression, Anorexia or Attention Deficit Disorder  Paralysis, Epilepsy, Stroke, Parkinson's Disease, Convulsions or Fainting  Sinusitis, Tonsillitis, or Adenoid Disorders  Stomach or Colon Disorders including Colitis, Diverticulosis, Diverticulitis, or Ulcers  Have you or any family members listed on the application received medical advice, been treated or diagnosed for any other condition(s), disease(s) or disorder(s) not listed above? Must check "Yes" or "No." If "Yes," specify and complete the detailed information below.  Are you or any family member expecting the birth of a child or the addition of any other dependent for whom you (or that other family member) may have a duty to provide medical care?  Are you or any family member listed on this application currently taking any prescription drugs or medicines — including narcotics, barbiturates or amphetamines?		
Back, Spine or Bone Diseases, or Arthritis					
Brain or Nervous System Disorder or Migraine Headaches					
Cancer or Malignant Conditions					
Cardiovascular Disorders, Chest Pain, Hypertension, Heart Disease or High Cholesterol					
Cataract or other Eye Disorders					
Cirrhosis, Hepatitis or other Liver Disorders					
Diabetes or other Endocrine (Glandular) Disorders					
Emphysema, Bronchitis, Asthma, or other Lung Disorders					
Gallbladder Disorders					
Hemorrhoids or other Rectal Disorders					
Hernias					
Kidney Disorders: Blood, Pus, Albumin, Sugar or Casts in Urine					
Male/Female Genital Disorders including Hysterectomy, Sterilization and Infertility Procedures					

Please provide information for any "Yes" answer you checked above. Include name of family member, nature of illness or injury, dates, duration of treatment and outcome, if applicable. Show specific names of medications and quantity taken, including milligrams and times per day. **ATTACH SEPARATE SHEET IF NECESSARY. (THIS SECTION MUST BE COMPLETED).**

FAMILY MEMBER NAME	ATTENDING PHYSICIAN, HOSPITAL OR CLINIC NAME AND COMPLETE ADDRESS	NAME OF CONDITION(S) ILLNESS(ES) TREATED	TREATMENT RENDERED SUCH AS CHECK-UP, X-RAY, LAB AND SURGICAL PROCEDURES, ETC. AND OUTCOME		
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED

Provide information for the questions listed below, for you and each family member to be covered. **If additional space is required, attach a separate sheet.**

Are you planning any hospitalization, medical or surgical treatment, or has any treatment been recommended for you or any family member listed on this application? If "Yes," give details:	YES	NO
Have you or any of your listed dependents, at any time in the past been declined health, disability or life insurance or had your health, disability or life insurance cancelled or rescinded? If "Yes" give reason(s):		
Have you or any family member listed on this application tested positive for the AIDS virus or are you or any family member listed in this application currently being treated for AIDS? If "Yes," please provide the name(s) of those testing positive or currently being treated for AIDS.		

**SECTION V.**

**AGREEMENT**

It is understood and agreed that the foregoing answers are true and shall be the basis for the issuance of the Membership Certificate applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void the Membership Certificate.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder, or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance.

I authorize release of any information regarding this application to my broker of record.

I understand that the purpose of the statement of health is to provide Anthem with information for determining the qualifications of myself (individual) and my family members (spouse and dependents) for the health coverage applied for and I agree that this statement of health shall become part of the contract between Anthem and myself.

The following authorization must be signed by the applicant and other adult persons, including adult dependents (e.g. age 18 or older in Nevada), to be covered. If the applicant does not sign this authorization, coverage cannot be issued. If any other adult person to be covered does not sign this authorization, coverage will not be extended to that person.

I hereby authorize that:

1. at the request of Anthem, any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem about health-related services and supplies provided to me, persons covered under my health coverage, or persons to be covered under my health coverage. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;
2. the Medical Review and Underwriting departments or agents of Anthem, upon receiving this information may use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement request, or a request or change in policy benefits.
3. unless I revoke this authorization, this authorization is valid for 24 months from the date I signed it, and
4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE, IF APPLICABLE on behalf of himself/herself and all other minor Person(s) <b>X</b>	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable <b>X</b>	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable <b>X</b>	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable <b>X</b>	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable <b>X</b>	DATE

If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application.

This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization, any information received by Anthem Blue Cross and Blue Shield pursuant to this authorization is subject to restrictions on disclosure to others as set forth under applicable federal and state laws.

PLEASE INDICATE IF YOU ARE SIGNING FOR A MINOR <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Trustee (If trustee or legal guardian, please supply legal documentation)	YOUR SOCIAL SECURITY NUMBER
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Incomplete Applications Will Be Returned. Have You . . .  
 Completed Health Statement?   Signed and Dated Application?  
**\*\*ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM\*\* OR FILL OUT THE CREDIT CARD AUTHORIZATION  
 (FORM NO. 98644) AND INCLUDE IT WITH THIS APPLICATION.**

## Monthly Bank Draft / Electronic Funds Transfer Authorization (Optional)

You can choose to have Anthem automatically deduct your premium from your checking account each month. Once your application is approved, your Electronic Funds Transfer Account (EFT) will be set up within 30 days from your effective date. Until the service is effective, Anthem will mail your bill for your monthly premium. To set up EFT, simply complete this section and be sure to include your first month's premium payment, or fill out the Initial Payment Only Credit Card Premium Payment section below, when you return your completed application.

Applicant's Name	
Bank Name	
Name(s) on Bank Account	
Your Bank's Routing Number	
Your Bank's Account Number	

John Smith 123 Main Street Denver, CO 80202	2213
Pay to the order of _____ \$ _____	Date _____
For _____ <small>1102456725: 1234567891011: 2213</small>	

**INTERNAL USE ONLY**

IPAD AUTO ID# \_\_\_\_\_

SUBSCRIBER # \_\_\_\_\_

COMPLETED DATE \_\_\_\_\_

↓     ↘     ↘  
 Bank Routing #    Account #    Check #

I authorize Anthem Blue Cross and Blue Shield (listed on bank statement as Rocky Mountain Health Care Corporation) to deduct my monthly premium payment due each month. The amount deducted each month will be a consistent amount unless there is a rate increase. If there is an outstanding balance forward due, plus my regular premium due, I will be asked to provide authorization to allow for the entire amount to be deducted. This agreement remains in effect until Anthem Blue Cross and Blue Shield receives a 30-day advance written notice from the Bank account holder or subscriber. In the event the Bank does not pay my health insurance for any reason, I understand that I am responsible for payment of the health insurance premiums. Failure to pay insurance premiums when due may result in termination of my coverage.

Signature (Exactly as it appear on bank records) :	Date:
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## Initial Payment Only Credit Card Premium Payment (Optional)

You may choose to make your **initial** premium payment by check, money order or credit card. Credit card payment is available for your first premium payment only. **All subsequent payments will be made through monthly bills.**

If choosing to pay by credit card, you must complete all of the following information:

VISA  MasterCard

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/> - <input style="width: 100%; height: 20px;" type="text"/>	\$ _____
Credit Card#	Expiration Date: (mm/yyyy)	Maximum Premium Amount Authorized

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	
Cardholder Signature:	Date:

INTERNAL USE ONLY: DO NOT WRITE BELOW THIS LINE

IPAD auto ID#	Subscriber #
Date Processed:	Processed by:

# HEALTH INSURANCE APPLICATION DISCLOSURE STATEMENT/ACKNOWLEDGEMENT

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I understand that I must complete, sign and return this Statement/Acknowledgement to Nevada Benefits prior to the start of the insurance application process.

I understand that as an application for health insurance coverage, it may take from four to six weeks (or longer), from the date I have completed and returned my application to **Nevada Benefits** until I am notified as to whether I have been approved for the coverage for which I apply.

I acknowledge that neither **Nevada Benefits** nor anyone else employed by or affiliated with **Nevada Benefits** has advised me or even suggested that I cancel or replace any existing insurance policy. Moreover, by executing this Statement/Acknowledgement I am affirmatively stating that I will not cancel any existing insurance coverage, which the policy I am applying for may replace, prior to receiving my approved policy from Nevada Benefits and determining that such policy is satisfactory for my individual needs.

I further agree and understand that should I cancel or replace any existing policy prior to being approved for the policy from Nevada Benefits, that I will be without insurance coverage if the policy for which I have applied is not approved. **Nevada Benefits** does not make underwriting decisions. The insurance company makes all underwriting decisions.

While I have made payment on the policy for which I have applied, I understand that said payment provides conditional coverage only. I also acknowledge that said payment in no way guarantees that my application will be approved. I further acknowledge that even though I have made a payment, I am prohibited by this Statement/Acknowledgement from canceling any existing insurance coverage the **Nevada Benefits'** policy might be replacing until I have first received my approved policy from **Nevada Benefits** and have determined that such policy is satisfactory for my individual needs.

I have read and I understand the pre-existing clause of the policy I have applied for.

Finally, I understand that any person who omits factual information or includes any false or misleading information on an application for insurance will void any insurance coverage, which would otherwise be afforded to me.

Applicant's Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

THIS DISCLOSURE FORM MUST BE SIGNED AND RETURNED WITH THE ENCLOSED APPLICATION.

**Nevada BluePreferred Monthly Rates for Individuals**  
**Effective April 1, 2007**  
**All Zip Codes beginning with 890 and 891**

Region: Las Vegas  
Standard Rates<sup>1</sup>

Age	\$500 deductible, \$30 copay, 80%/50% , \$15/40/60 Rx		\$1000 deductible, \$35 copay, 80%/50% , \$15/40/60 Rx		\$2000 deductible, \$40 copay, 70%/50% , \$15/40/60 Rx		\$500 deductible, \$35 copay, 50%/50% , no Rx		\$3,000 deductible, no copay, 70%/50% , \$15/40/60 Rx	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-24	\$154	\$192	\$130	\$164	\$97	\$128	\$116	\$145	\$85	\$112
25-29	\$171	\$212	\$145	\$182	\$110	\$142	\$130	\$160	\$96	\$125
30-34	\$178	\$237	\$152	\$204	\$116	\$160	\$135	\$179	\$102	\$140
35-39	\$194	\$262	\$165	\$226	\$128	\$179	\$146	\$198	\$112	\$157
40-44	\$231	\$303	\$198	\$262	\$155	\$209	\$175	\$229	\$136	\$182
45-49	\$272	\$328	\$235	\$284	\$186	\$228	\$206	\$248	\$163	\$199
50-54	\$347	\$349	\$301	\$303	\$242	\$245	\$262	\$263	\$211	\$214
55-59	\$448	\$430	\$390	\$374	\$317	\$304	\$339	\$324	\$278	\$266
60-64	\$565	\$502	\$492	\$437	\$407	\$359	\$427	\$380	\$356	\$315
1 Dep. Child	\$114	\$114	\$98	\$98	\$77	\$77	\$86	\$86	\$67	\$67
2 Dep. Children	\$228	\$228	\$196	\$196	\$154	\$154	\$172	\$172	\$134	\$134
3+ Dep. Children	\$343	\$343	\$294	\$294	\$230	\$230	\$259	\$259	\$202	\$202

Region: Las Vegas  
Tobacco User Rates<sup>2</sup>

Age	\$500 deductible, \$30 copay, 80%/50% , \$15/40/60 Rx		\$1000 deductible, \$35 copay, 80%/50% , \$15/40/60 Rx		\$2000 deductible, \$40 copay, 70%/50% , \$15/40/60 Rx		\$500 deductible, \$35 copay, 50%/50% , no Rx		\$3,000 deductible, no copay, 70%/50% , \$15/40/60 Rx	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-24	\$184	\$230	\$156	\$196	\$116	\$153	\$139	\$174	\$102	\$134
25-29	\$205	\$254	\$174	\$218	\$132	\$170	\$156	\$192	\$115	\$150
30-34	\$213	\$284	\$182	\$244	\$139	\$192	\$162	\$214	\$122	\$168
35-39	\$232	\$314	\$198	\$271	\$153	\$214	\$175	\$237	\$134	\$188
40-44	\$277	\$363	\$237	\$314	\$186	\$250	\$210	\$274	\$163	\$218
45-49	\$326	\$393	\$282	\$340	\$223	\$273	\$247	\$297	\$195	\$238
50-54	\$416	\$418	\$361	\$363	\$290	\$294	\$314	\$315	\$253	\$256
55-59	\$537	\$516	\$468	\$448	\$380	\$364	\$406	\$388	\$333	\$319
60-64	\$678	\$602	\$590	\$524	\$488	\$430	\$512	\$456	\$427	\$378
1 Dep. Child	\$136	\$136	\$117	\$117	\$92	\$92	\$103	\$103	\$80	\$80
2 Dep. Children	\$273	\$273	\$235	\$235	\$184	\$184	\$206	\$206	\$160	\$160
3+ Dep. Children	\$411	\$411	\$352	\$352	\$276	\$276	\$310	\$310	\$242	\$242

<sup>1</sup>These rates are level 1 (standard) rates. Rates may be higher based on an individual's underwriting review.

<sup>2</sup>These rates are tobacco-user rates. Rates may be higher based on an individual's underwriting review.

# 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)

<b>500-30-80/50</b>	<b>In-Network</b> Individual: \$500.00, Family: \$1,500.00; <b>Out-of-Network</b> Individual: \$1,000.00, Family: \$3,000.00
<b>500-35-50/50</b>	<b>In-Network</b> Individual: \$500.00, Family: \$1,500.00; <b>Out-of-Network</b> Individual: \$1,000.00, Family: \$3,000.00
<b>1000-35-80/50</b>	<b>In-Network</b> Individual: \$1,000.00, Family: \$3,000.00; <b>Out-of-Network</b> Individual: \$2,000.00, Family: \$6,000.00
<b>2000-40-70/50</b>	<b>In-Network</b> Individual: \$2,000.00, Family: \$6,000.00; <b>Out-of-Network</b> Individual: \$4,000.00, Family: \$12,000.00
<b>3000-70/50</b>	<b>In-Network</b> Individual: \$3,000.00, Family: \$9,000.00; <b>Out-of-Network</b> 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	
<b>Ambulance Services</b>  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.
<b>Alcohol and Drug Abuse</b>  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%	
<b>Chemotherapy, Hemodialysis, and Radiation Therapy</b> Inpatient/Outpatient  500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					
<b>Diagnostic Services, Laboratory, Pathology, and X-ray</b> 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.
<b>Emergency Care *</b>  500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50					

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Services	In-Network after Deductible		Out-of-Network after Deductible		Additional Information
<b>Home Health Care</b>  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.
<b>Hospice Care</b>  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.
<b>Hospital Care</b> 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					
<b>Maternity Care</b>  500-30-80/50  500-35-50/50  1000-35-80/50  2000-40-70/50  3000-70/50	<b>Inpatient</b>  80%  50%  80%  70%  70%	<b>Outpatient</b>  \$30 copay per visit  \$35 copay per visit  \$35 copay per visit  \$40 copay per visit  70%	<b>Inpatient</b>  50%  50%  50%  50%  50%	<b>Outpatient</b>  50%  50%  50%  50%  50%	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
<b>Severe Mental Illness</b>  500-30-80/50 500-35-50/50 1000-35-80/50 2000-40-70/50 3000-70/50	<b>Inpatient</b>  70% 50% 70% 70% 70%	<b>Outpatient</b>  70% 50% 70% 70% 70%	<b>Inpatient</b>  50% 50% 50% 50% 50%	<b>Outpatient</b>  50% 50% 50% 50% 50%	Benefits are paid up to 40 inpatient days, 80 partial days (combined). Benefits are paid up to 40 visits per calendar year.
<b>Physical Rehabilitation (physical, occupational, and speech therapy)</b> 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
<b>Physician Visits</b>			
<b>500-30-80/50</b>			
Inpatient	80%	50%	
Outpatient	\$30 copayment per visit	50%	
Outpatient – urgent	\$60 copayment per visit	50%	
<b>500-35-50/50</b>			
Inpatient	50%	50%	
Outpatient	\$35 copayment per visit	50%	
Outpatient – urgent	\$70 copayment per visit	50%	
<b>1000-35-80/50</b>			
Inpatient	80%	50%	
Outpatient	\$35 copayment per visit	50%	
Outpatient – urgent	\$70 copayment per visit	50%	
<b>2000-40-70/50</b>			
Inpatient	70%	50%	
Outpatient	\$40 copayment per visit	50%	
Outpatient – urgent	\$80 copayment per visit	50%	
<b>3000-70/50</b>			
Inpatient	70%	50%	
Outpatient	70%	50%	
Outpatient – urgent	70%	50%	
<b>Preventive Care</b>			
<b>500-30-80/50</b>			
A. Children	80% not subject to deductible	50%	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.
- routine child exam to age 13			
- immunizations to age 13			
B. Adults	80% not subject to deductible	50%	
- routine pap smear	\$75 maximum payment for laboratory charges	\$85 maximum payment	
- routine mammography	\$85 maximum payment	\$65 maximum payment	
- routine prostate screening	\$65 maximum payment		
<b>500-35-50/50</b>			
A. Children	50% not subject to deductible	50%	
- routine child exam to age 13			
- immunizations to age 13			
B. Adults	50% not subject to deductible	50%	
- routine pap smear	\$75 maximum payment for laboratory charges	\$85 maximum payment	
- routine mammography	\$85 maximum payment	\$65 maximum payment	
- routine prostate screening	\$65 maximum payment		
<b>1000-35-80/50</b>			
A. Children	80% not subject to deductible	50%	
- routine child exam to age 13			
- immunizations to age 13			
B. Adults	80% not subject to deductible	50%	
- routine pap smear	\$75 maximum payment for laboratory charges	\$85 maximum payment	
- routine mammography	\$85 maximum payment	\$65 maximum payment	
routine prostate screening	\$65 maximum payment		

Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
<b>2000-40-70/50</b> 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	
<b>3000-70/50</b> 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 \$85 maximum payment	
<b>Spinal Manipulations</b>  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.
<b>Supplies, Equipment, and Appliances (DME)</b> 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%	
<b>Temporomandibular Joint Syndrome (TMJ)</b>  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.

<b>DENTAL INJURY:</b>	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.
<b>OUTPATIENT PRESCRIPTION DRUGS:</b>	<p><b>500-30-80/50:</b> 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).</p> <p><b>500-35-50/50:</b> 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.</p> <p><b>1000-35-80/50:</b> 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).</p> <p><b>2000-40-70/50:</b> 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).</p>

	<b>3000-70/50:</b> 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).	
<b>DEPENDENT ELIGIBILITY:</b>	The end of the month in which the employee's unmarried dependent child becomes age 19, or 24 if financially dependent upon the subscriber.	
<b>PRECERTIFICATION PRIOR AUTHORIZATION PENALTIES:</b>	<b>Inpatient Services:</b> 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.	<b>Outpatient Services:</b> 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.
<b>MAXIMUM OUT-OF-POCKET EXPENSE AMOUNT:</b> (Does not apply to TMJ care)	<b>Preferred Providers:</b>  <b>500-30-80/50:</b> 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.  <b>500-35-50/50:</b> 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.  <b>1000-35-80/50:</b> 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.  <b>2000-40-70/50:</b> 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.  <b>3000-70/50:</b> 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.	<b>Non-Preferred Providers:</b>  <b>500-30-80/50:</b> 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.  <b>500-35-50/50:</b> 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.  <b>1000-35-80/50:</b> 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.  <b>2000-40-70/50:</b> 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.  <b>3000-70/50:</b> 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.
<b>LIFETIME MAXIMUM BENEFITS:</b>	\$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.

## Vision Benefit in BluePreferred for Individual Plans - Nevada

Current Plan		All BluePreferred for Individuals Plans		
Vision Non medical conditions	Vision Non medical conditions	Member Benefit From Network Provider	Non-Network Reimbursement**	
Not covered	<p><b>Vision Examination:</b> Each member is entitled to a comprehensive vision examination by an Anthem Provider. <b>Availability : Once every 12 months*</b></p> <p><b>Lenses:</b> 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. <b>Single Vision Lenses (pair)</b></p> <p><b>Bifocal Lenses (pair)</b></p> <p><b>Progressive Lenses (pair)</b></p> <p><b>Trifocal Lenses (pair)</b></p> <p><b>Lenticular</b></p> <p><b>Availability : Once every 12 months*</b></p>	<p>\$30/\$35/\$40 Copayment depending on plan</p> <p>\$30/\$35/\$40 Materials copayment applies to lenses and frames</p> <p>\$30/\$35/\$40 Copayment</p> <p>\$30/\$35/\$40 Copayment</p> <p>\$30/\$35/\$40 Copayment</p> <p>– Maximum Allowable Amount equal to bifocal amount. Member pays difference. \$30/\$35/\$40 Copayment</p> <p>\$30/\$35/\$40 Copayment</p>	<p>Up to \$35.00</p> <p>Up to \$25.00</p> <p>Up to \$40.00</p> <p>Up to \$40.00</p> <p>Up to \$55.00</p> <p>Up to \$80.00</p>	
	<p><b>Current MV Plans:</b></p> <ul style="list-style-type: none"> <li>• \$500 deductible, \$30 OV co-pay, 30/30 vision</li> <li>• \$1,000 deductible, \$35 OV co-pay, 35/35 vision</li> <li>• \$2,000 deductible, \$40 OV co-pay, 40/40 vision</li> <li>• \$500 ded/50% coins, \$35 OV co-pay, 35/35 vision</li> <li>• \$3,000 ded, OV subject to deductibles: 40/40 vision</li> </ul>	<p><b>Frames:</b> Maximum Allowable Amount of <b>\$120.00</b> (retail) for frames purchased from Network Provider. Member pays Preferred Price in excess of Maximum Allowable Amount. <b>Availability : Once every 24 months*</b></p> <p><b>Contact Lenses***:</b></p> <p><b>Elective -</b> Members have a <b>\$105.00</b> plan allowance per benefit period toward cosmetic contact lenses in lieu of the frame and lens benefits. If the member chooses contact lenses greater than the plan allowance, the member is responsible for the difference. <b>Medically Necessary</b> <b>Availability : Once every 12 months*</b></p>	<p>\$30/\$35/\$40 Copayment</p> <p>Plan provides 10% discount on disposable lenses and 15% on other traditional lenses.</p> <p>\$30/\$35/\$40 Copayment</p>	<p>Up to \$80.00</p> <p>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.