health insurance • life insurance • disability insurance • retirement planning

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 775-201-1326.

If you have questions, please give us a call at 686-6010. Your completed application can be mailed to the address listed below or in the enclosed envelope provided.

One East Liberty 6th Floor• Reno, NV 89504 • (775) 686-6010 • Fax (775) 201-1326
www.nevadabenefits.com • Nevada License # 6266

SECTION I
Nevada BluePreferred for Individuals
Application For Individual/Family Enrollment

Broker Name: Nevada Benefits
Broker Number: 23397

BROKER SIGNATURE X Phil Randazzo | DATE

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

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

APPLICATION TYPE (Check Appropriate box) ☐ NEW ENROLLMENT ☐ ADD FAMILY MEMBER Indicate Existing Subscriber No. ____

☐ 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 / DEDUCTIBLE SELECT ONE

☐ Individual ☐ Family

☐ $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 ☐ Male ☐ Female	BIRTHDATE (Mo. Day Yr)	HEIGHT	WEIGHT

PHYSICAL STREET ADDRESS	HOME TELEPHONE ( )	WORK TELEPHONE ( )

CITY	STATE	ZIP CODE	OCCUPATION	GROSS ANNUAL INCOME
	NV			

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

IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES CHECK APPLICABLE BOX

☐ PROFESSIONAL ☐ MAIDEN ☐ OTHER—Explain ____

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 Overage 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 Month	Day	Year	HEIGHT	WEIGHT

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		
Back, Spine or Bone Diseases, or Arthritis			Paralysis, Epilepsy, Stroke, Parkinson's Disease, Convulsions or Fainting		
Brain or Nervous System Disorder or Migraine Headaches			Sinusitis, Tonsillitis, or Adenoid Disorders		
Cancer or Malignant Conditions			Stomach or Colon Disorders including Colitis, Diverticulosis, Diverticulitis, or Ulcers		
Cardiovascular Disorders, Chest Pain, Hypertension, Heart Disease or High Cholesterol			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.		
Cataract or other Eye Disorders					
Cirrhosis, Hepatitis or other Liver Disorders					
Diabetes or other Endocrine (Glandular) Disorders					
Emphysema, Bronchitis, Asthma, or other Lung Disorders			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?		
Gallbladder Disorders					
Hemorrhoids or other Rectal Disorders					
Hernias					
Kidney Disorders: Blood, Pus, Albumin, Sugar or Casts in Urine			Are you or any family member listed on this application currently taking any prescription drugs or medicines — including narcotics, barbiturates or amphetamines?		
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.**

	YES	NO
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:		
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) X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	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 ☐ Parent ☐ Legal Guardian ☐ Trustee (If trustee or legal guardian, please supply legal documentation)	YOUR SOCIAL SECURITY NUMBER

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.

Anthem.

Monthly Bank Draft / Electronic Funds Transfer Authorization (Optional)

You can chose 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	

2213

John Smith
123 Main Street
Denver, CO 80202

Date__________

Pay to the order of__________________ $________

For__________

1102456725: 1234567891011: 2213

Bank Routing # Account # Check #

INTERNAL USE ONLY

IPAD AUTO ID#__________

SUBSCRIBER #__________

COMPLETED DATE__________

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:

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐-☐☐☐☐ $__________

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:

FORM NO. 98644 An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association

HEALTH INSURANCE APPLICATION
DISCLOSURE STATEMENT/ACKNOWLEDGEMENT

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.

Anthem

ANTHEM BLUE CROSS AND BLUE SHIELD
BluePreferred

Filed Rates effective April 1, 2008

Health Status / Underwriting Factors: 1.000, 1.200, 1.250, 1.333, 1.400, 1.500, 1.750
Note: Level 1 and Smoker rates are shown only (multiply by Health Status / Underwriting Factors to calculate other rating levels)

Region: Las Vegas

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			
Band	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker
< 1	$147	$176	$147	$176	$122	$146	$122	$146	$98	$117	$98	$117	$111	$133	$111	$133	$85	$102	$85	$102
01-02	$147	$176	$147	$176	$122	$146	$122	$146	$98	$117	$98	$117	$111	$133	$111	$133	$85	$102	$85	$102
03-18	$138	$165	$138	$165	$113	$135	$113	$135	$91	$109	$91	$109	$104	$124	$104	$124	$79	$94	$79	$94
19-24	$183	$219	$233	$279	$137	$164	$191	$229	$109	$130	$152	$182	$138	$165	$176	$211	$96	$115	$133	$159
25-29	$207	$248	$256	$307	$160	$192	$212	$254	$127	$152	$169	$202	$157	$188	$193	$231	$111	$133	$148	$177
30-34	$212	$254	$289	$346	$168	$201	$241	$289	$134	$160	$193	$231	$160	$192	$219	$262	$117	$140	$169	$202
35-39	$232	$278	$316	$379	$188	$225	$270	$324	$150	$180	$215	$258	$176	$211	$239	$286	$132	$158	$188	$225
40-44	$264	$316	$353	$423	$220	$264	$304	$364	$176	$211	$243	$291	$200	$240	$267	$320	$154	$184	$212	$254
45-49	$313	$375	$374	$448	$268	$321	$327	$392	$214	$256	$261	$313	$237	$284	$283	$339	$187	$224	$229	$274
50-54	$408	$489	$394	$472	$357	$428	$350	$420	$285	$342	$279	$334	$308	$369	$298	$357	$249	$298	$244	$292
55-59	$530	$636	$485	$582	$476	$571	$436	$523	$380	$456	$348	$417	$401	$481	$366	$439	$333	$399	$305	$366
60-64	$689	$826	$596	$715	$635	$762	$544	$652	$507	$608	$435	$522	$521	$625	$451	$541	$444	$532	$380	$456

Region: Reno and Rural

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			
Band	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker	Male	M Smoker	Female	F Smoker
< 1	$132	$158	$132	$158	$109	$131	$109	$131	$88	$105	$88	$105	$99	$119	$99	$119	$76	$91	$76	$91
01-02	$132	$158	$132	$158	$109	$131	$109	$131	$88	$105	$88	$105	$99	$119	$99	$119	$76	$91	$76	$91
03-18	$124	$149	$124	$149	$101	$122	$101	$122	$81	$98	$81	$98	$93	$112	$93	$112	$71	$85	$71	$85
19-24	$164	$197	$209	$251	$123	$147	$171	$206	$98	$117	$136	$164	$124	$149	$158	$190	$86	$103	$119	$143
25-29	$186	$223	$230	$276	$144	$172	$190	$228	$114	$137	$152	$182	$141	$169	$173	$208	$99	$119	$133	$159
30-34	$190	$228	$260	$312	$151	$181	$216	$260	$120	$144	$173	$208	$144	$172	$197	$236	$105	$126	$152	$182
35-39	$208	$250	$284	$341	$169	$203	$243	$291	$135	$162	$193	$232	$158	$190	$215	$258	$118	$142	$169	$203
40-44	$237	$285	$317	$381	$198	$237	$273	$328	$158	$190	$218	$262	$180	$216	$240	$288	$138	$166	$190	$228
45-49	$281	$338	$336	$403	$241	$289	$294	$353	$192	$231	$234	$281	$213	$255	$254	$305	$168	$201	$206	$247
50-54	$367	$440	$354	$425	$321	$385	$315	$378	$256	$307	$251	$301	$277	$332	$268	$321	$224	$268	$219	$263
55-59	$477	$572	$436	$523	$428	$514	$392	$470	$342	$410	$313	$375	$360	$433	$329	$395	$299	$359	$274	$329
60-64	$620	$744	$536	$643	$571	$685	$489	$587	$456	$547	$391	$469	$468	$562	$405	$487	$399	$479	$342	$410

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.
An independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark.
The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

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

country and around the world. Our BlueCard PPO program gives you access to doctors and hospitals almost everywhere in the U.S. This is a real plus when you travel or if you have eligible family members who live out of state. Even abroad, BluePreferred pays 50 percent of covered services, including emergency care.

More than 80 percent of U.S. hospitals and more than 90 percent of physicians accept Blue Cross and Blue Shield cards.

Important Numbers

Individual Sales
1-800-873-2261

Customer Service
1-800-992-6907

Precertification for Surgery and Inpatient Hospital Care
1-800-782-7484

Network Providers
1-800-992-6907 or
www.anthem.com

BlueCard Away From Home Care
BlueCard 1-800-810-BLUE
www.BCBS.com

For provider information, FAQ's, health-related topics and so much more, log on to www.anthem.com!

Surprisingly Affordable Rates

For those without employer-sponsored insurance, the prospect of not having health benefits at all is very real. At Anthem Blue Cross and Blue Shield, we understand that comprehensive coverage, convenience and choice are all very desirable—but without affordable rates, few could enjoy the security of Blue.

We encourage you to shop around. Compare our benefits and service with other major health plans. We think you will be pleasantly surprised how BluePreferred rates compare!

Payment Convenience

At Anthem Blue Cross and Blue Shield, we offer the convenience of automatic payments from your personal bank account. Our Automatic Pay service saves you time and postage, and ensures your monthly premium payments arrive on time.

Automatic Pay is available to all BluePreferred for Individuals members and is entirely voluntary. To apply for Automatic Pay, just complete the enclosed authorization form and mail it along with a voided check in the postage-paid envelope.

How to Enroll

To enroll in BluePreferred PPO for Individuals, please complete the member application and mail it, along with a check for the first month's premium, in the enclosed postage-paid envelope.

Mail the application four weeks before you want your coverage to begin. Once you're approved for the plan, we will send you your health plan ID card and detailed benefit information.

Security From a Name You Can Count On

BluePreferred PPO for Individuals is brought to you by Anthem Blue Cross and Blue Shield, an industry leader that provides health care benefits and services to more than 7.6 million Americans. Our mission is to improve the health of the people we serve. We appreciate the opportunity to serve you.

One in Four Americans Is Protected by the Cross and Shield.

Decide to be healthy.℠

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[1]	Annual Deductible[2] In-Network Individual/Family	Coinsurance[3] Plan Pays Network/Non-Network	In-Network Out-of-Pocket Maximum[4] Individual/Family
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

Deductibles and Out-of-Pocket Maximums are higher for non-network services.

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

Added Value Everyone Can Use

Decide to be healthy.℠

Anthem's BluePreferred for Individuals health plan now includes two new features that enhance plan value for all members.

New Vision Care Benefits

At Anthem Blue Cross and Blue Shield, we're committed to improving the health of our members. That includes helping you maintain good eye health.

As a BluePreferred for Individuals plan member, you now can enjoy coverage for comprehensive eye exams, eyeglasses and contact lenses. When you use Anthem Vision network providers for covered services, you'll simply pay a copay* at the time of each service or hardware purchase, and the plan will cover the rest, up to specific limits.

Just for Members: "Preferred Pricing" from Network Providers

We've also arranged for you to receive "preferred pricing" from Anthem Vision network providers. That means you'll receive discounts on sunglasses, reading glasses, spare pairs and other sundry items—just for being a BluePreferred health plan member. Simply present your health plan ID card at the time of purchase.

Using the Anthem Vision Network

The Anthem Vision network includes more than 10,000 optometrists, opthalmologists and retail providers across the United States. To find a network provider near you, call toll-free 1-800-231-2583 to speak with an Anthem Vision Customer Service representative. Or, visit our Web site at *www.anthem.com* to access our online provider directory. You can even print a map and driving directions!

When you schedule an appointment, be sure to inform the provider that you have Anthem Vision benefits, so he or she can obtain your plan information in advance. At the time of service, you'll simply pay your copay. As long as you use network providers, the plan requires no paperwork from you. PLEASE NOTE: If you choose to receive care from a non-network provider, benefits will be paid at a lower, non-network level, and you will be required to file a claim for reimbursement.

For benefit details, call Anthem Vision Customer Service at 1-800-231-2583. Through this number you may either speak directly with an Anthem Vision representative or use our automated IVR system to obtain benefit details.

Why Cover Eye Exams?

In addition to creating serious safety risks, poor vision can contribute to headaches, and neck or back strain. Comprehensive eye exams can detect diseases of the eye, such as glaucoma, as well as illness elsewhere in the body, such as diabetes, tumors of the pituitary, blood disorders, arthritis and other connective tissue disorders.

Save Up to 65% with SpecialOffers@Anthem

As a member of BluePreferred for Individuals, you also have access to SpecialOffers@Anthem. This Web-based program offers members great discounts on an array of products and services, such as over-the-counter drugs, supplements, baby safety products and more.

To access SpecialOffers@Anthem, log on to *www.anthem.com.* Sign in as a health plan member, then press the "SpecialOffers@Anthem" link. Be sure to check back often, as new products and services will be continually added to the Web site.

At Anthem Blue Cross and Blue Shield, our mission is to improve the health of the people we serve. That means taking care you—and always finding new ways to deliver better value. You can count on Anthem for more choice, easy access, great value and savings! We appreciate the opportunity to serve you.

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® Registered marks Blue Cross and Blue Shield Association

** The vision copay for all Colorado members is $25. The vision copay for Nevada members who have the $3,000 deductible plan is $40. The vision copay for all other Nevada members is equal to your health plan's office visit copay.*

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Anthem.

BluePreferred for Individuals Plan 500-30-80/50

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)
In-Network: Individual: $500.00, Family: $1,500.00; **Out-of-Network:** Individual: $1,000.00, Family: $3,000.00

Services	In-Network after Deductible		Out-of-Network after Deductible		Additional Information
Ambulance Services	**Ground Services** 80%	**Air Services** 80%	**Ground Services** 80%	**Air Services** 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	**Inpatient** 80%	**Outpatient** 80%	**Inpatient** 50%	**Outpatient** 50%	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.
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	80%		50%		
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient	80%		50%		Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
Emergency Care *	80%		50%		
Home Health Care	80%		50%		Benefits are limited to 60 visits per calendar year.
Hospice Care	80%		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	80%		50%		
Maternity Care	**Inpatient** 80%	**Outpatient** $30 copay per visit	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
Severe Mental Illness	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid up to 40 inpatient days, 80 partial days (combined). Benefits are paid up to 40 visits per calendar year.
Physical Rehabilitation (physical, occupational, and speech therapy) Inpatient and Outpatient	80%		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.
Physician Visits Inpatient Outpatient Outpatient – urgent	80% $30 copayment per visit $60 copayment per visit		50% 50% 50%		

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Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Preventive Care			
A. Children - routine child exam to age 13 - immunizations to age 13	80% not subject to deductible	50%	
B. Adults	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 pap smear	$75 maximum payment for laboratory charges		
- routine mammography	$85 maximum payment	$85 maximum payment	
- routine prostate screening	$65 maximum payment	$65 maximum payment	
Spinal Manipulations	80%	50%	Benefits are limited to a maximum payment of $200 per calendar year per member.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	80%	50%	
Temporomandibular Joint Syndrome (TMJ)	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:	Participating Retail Pharmacy: Generic $15 copayment; Brand Formulary $40 copayment; Non-Formulary $60 copayment (up to a 34-day supply). Mailorder: 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:** 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.	**Non-Preferred Providers:** 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.
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.

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BluePreferred for Individuals Plan 1000-35-80/50

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)
In-Network: Individual: $1,000.00, Family: $3,000.00; **Out-of-Network**: Individual: $2,000.00, Family: $6,000.00

Services	In-Network after Deductible		Out-of-Network after Deductible		Additional Information
Ambulance Services	**Ground Services** 80%	**Air Services** 80%	**Ground Services** 80%	**Air Services** 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	**Inpatient** 80%	**Outpatient** 80%	**Inpatient** 50%	**Outpatient** 50%	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.
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	80%		50%		
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient	80%		50%		Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
Emergency Care *	80%		50%		
Home Health Care	80%		50%		Benefits are limited to 60 visits per calendar year.
Hospice Care	80%		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	80%		50%		
Maternity Care	**Inpatient** 80%	**Outpatient** $35 copay per visit	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
Severe Mental Illness	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid up to 40 inpatient days, 80 partial days (combined). Benefits are paid up to 40 visits per calendar year.
Physical Rehabilitation (physical, occupational, and speech therapy) Inpatient and Outpatient	80%		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.
Physician Visits Inpatient Outpatient Outpatient – urgent	80% $35 copayment per visit $70 copayment per visit		50% 50% 50%		

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Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Preventive Care			
A. Children - routine child exam to age 13 - immunizations to age 13	80% not subject to deductible	50%	
B. Adults	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 pap smear	$75 maximum payment for laboratory charges		
- routine mammography	$85 maximum payment	$85 maximum payment	
- routine prostate screening	$65 maximum payment	$65 maximum payment	
Spinal Manipulations	80%	50%	Benefits are limited to a maximum payment of $200 per calendar year per member.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	80%	50%	
Temporomandibular Joint Syndrome (TMJ)	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:	Participating Retail Pharmacy: Generic $15 copayment; Brand Formulary $40 copayment; Non-Formulary $60 copayment (up to a 34-day supply). Mailorder: 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:** 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.	**Non-Preferred Providers:** 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.
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.

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BluePreferred for Individuals Plan 2000-40-70/50

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)
In-Network: Individual: $2,000.00, Family: $6,000.00; **Out-of-Network:** Individual: $4,000.00, Family: $12,000.00

Services	In-Network after Deductible		Out-of-Network after Deductible		Additional Information
Ambulance Services	**Ground Services** 70%	**Air Services** 70%	**Ground Services** 70%	**Air Services** 70%	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	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	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.
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	70%		50%		
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient	70%		50%		Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
Emergency Care *	70%		50%		
Home Health Care	70%		50%		Benefits are limited to 60 visits per calendar year.
Hospice Care	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	70%		50%		
Maternity Care	**Inpatient** 70%	**Outpatient** $40 copayment per visit	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
Severe Mental Illness	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid up to 40 inpatient days, 80 partial days (combined). Benefits are paid up to 40 visits per calendar year.
Physical Rehabilitation (physical, occupational, and speech therapy) Inpatient and Outpatient	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.
Physician Visits Inpatient Outpatient Outpatient – urgent	70% $40 copayment per visit $80 copayment per visit		50% 50% 50%		

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Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Preventive Care			
A. Children - routine child exam to age 13 - immunizations to age 13	70% not subject to deductible	50%	
B. Adults	70% 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 pap smear	$75 maximum payment for laboratory charges		
- routine mammography	$85 maximum payment	$85 maximum payment	
- routine prostate screening	$65 maximum payment	$65 maximum payment	
Spinal Manipulations	70%	50%	Benefits are limited to a maximum payment of $200 per calendar year per member.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	70%	50%	
Temporomandibular Joint Syndrome (TMJ)	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:	Participating Retail Pharmacy: Generic $15 copayment; Brand Formulary $40 copayment; Non-Formulary $60 copayment (up to a 34-day supply). Mailorder: 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:** Individual: You pay ~~20~~30 percent of the Allowable Charge up to ~~$3,000~~4,500 plus deductible and copayments. Family: You pay ~~20~~30 percent of the Allowable Charge up to ~~$6,000~~9,000 plus deductible and copayments.	**Non-Preferred Providers:** Individual: You pay 50 percent of the Allowable Charge up to ~~$6,000~~7,500 plus deductible. Family: You pay 50 percent of the Allowable Charge up to ~~$12,000~~15,000 plus deductible.
LIFETIME MAXIMUM BENEFITS:	$2,000,000 per member.	

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***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

BluePreferred for Individuals Plan 3000-70/50

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)
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
Ambulance Services	**Ground Services** 70%	**Air Services** 70%	**Ground Services** 70%	**Air Services** 70%	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	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	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.
Chemotherapy, Hemodialysis, and Radiation Therapy Inpatient/Outpatient	70%		50%		
Diagnostic Services, Laboratory, Pathology, and X-ray Inpatient/Outpatient	70%		50%		Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
Emergency Care *	70%		50%		
Home Health Care	70%		50%		Benefits are limited to 60 visits per calendar year.
Hospice Care	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	70%		50%		
Maternity Care	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
Severe Mental Illness	**Inpatient** 70%	**Outpatient** 70%	**Inpatient** 50%	**Outpatient** 50%	Benefits are paid up to 40 inpatient days, 80 partial days (combined). Benefits are paid up to 40 visits per calendar year.
Physical Rehabilitation (physical, occupational, and speech therapy) Inpatient and Outpatient	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.
Physician Visits Inpatient Outpatient Outpatient – urgent	 70% 70% 70%		 50% 50% 50%		

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Services	In-Network after Deductible	Out-of-Network after Deductible	Additional Information
Preventive Care			
A. Children - routine child exam to age 13 - immunizations to age 13	70% not subject to deductible	50%	
B. Adults	70% 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 pap smear	$75 maximum payment for laboratory charges		
- routine mammography	$85 maximum payment	$85 maximum payment	
- routine prostate screening	$65 maximum payment	$65 maximum payment	
Spinal Manipulations	70%	50%	Benefits are limited to a maximum payment of $200 per calendar year per member.
Supplies, Equipment, and Appliances (DME) Inpatient/Outpatient	70%	50%	
Temporomandibular Joint Syndrome (TMJ)	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:	Participating Retail Pharmacy: Generic $15 copayment; Brand Formulary $40 copayment; Non-Formulary $60 copayment (up to a 34-day supply). Mailorder: 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:** 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:** 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.	

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