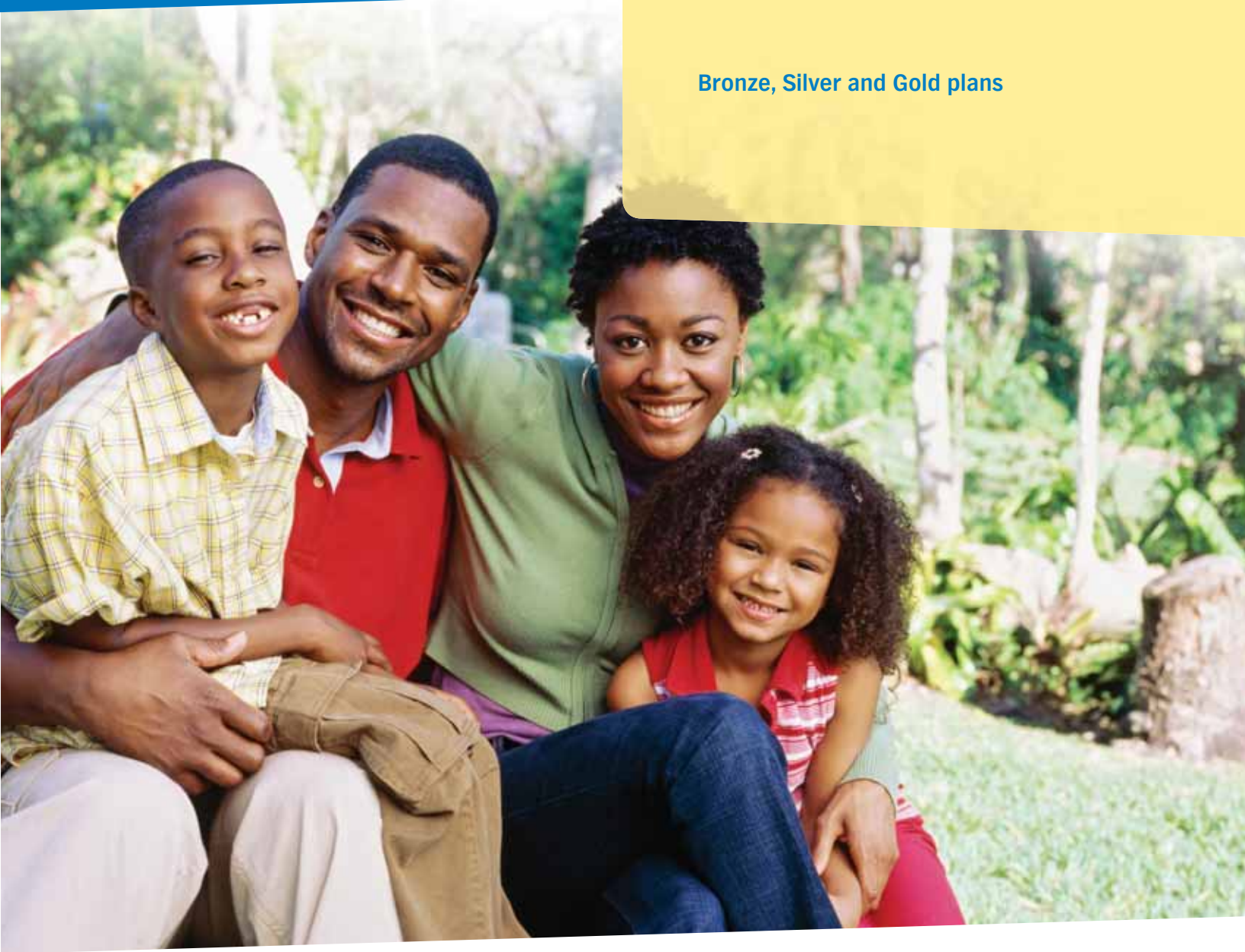
Individual and family health benefit plans for Nevada

We make it easy

Looking for a new health plan? We can help.

Anthem BlueCross BlueShield

Bronze, Silver and Gold plans



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Health care on your terms

When it comes to individual health care coverage, it's not one-size-fits-all. Anthem Blue Cross and Blue Shield (Anthem), through its subsidiary company, HMO Colorado, Inc. dba HMO Nevada, offers you a range of options so you can compare plans and find the best coverage for your need and budget. No one knows what you and your family needs better than you. Just let us know and we're here to help when and where you need us.

Take control of your health

When you choose Anthem, you don't just get a health plan. You get a total health coverage solution that can help you live healthier and feel your best, while saving money along the way. With Anthem, you get:

- $0 cost preventive care[1] (like checkups and flu shots) with no deductible or copay when you see in-network providers
- Guaranteed coverage, no matter what your health
- Prescription drug benefits at local and nationally recognized pharmacies, plus a mobile app to help you find a pharmacy, order a refill, check order status and more
- 24/7 NurseLine so you can speak to a nurse any time of the day or night and online support whenever you have questions
- The LiveHealth Online tool that lets you video chat with a doctor through your mobile device or a computer with a webcam about common health concerns like colds and the flu
- The Away From Home Care or Guest Membership program that allows approved covered dependents temporarily living away from home to become guests on an affiliated Blue Cross and Blue Shield HMO plan in the area where they're staying
- Care support programs to help you take care of chronic or complex health problems
- No lifetime dollar maximums on covered services
- Easy-to-use tools to find a doctor, hospital or pharmacy

Health plans don't have to be hard to figure out. See how easy it can be with Anthem.

- ***Personalized help.*** If you're trying to decide which plan will work best, we've got answers for you.
- ***Access to quality care.*** Make sure you're getting the quality health insurance you want. Make sure you get Anthem.
- ***Reliable customer service.*** Our associates are dedicated to giving you the help you need, when you need it.
- ***Simple.*** Health care coverage isn't always easy to understand. We'll help you make sense of it.
- ***Stable.*** One thing is clear about the changes in health care coverage - you can count on us to be there for you.

Call your broker or Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

Access the benefits that matter to you

All of our plan options have one major goal in mind: To help you stay healthy and find the quality coverage you need when you need it. That's why, no matter which plan you choose, you're covered from preventive care to emergencies, and more!

What's covered?

- In-network preventive care services, including screenings, and help managing a chronic (ongoing) disease
- Outpatient services
- Emergency services, like going to the emergency room (ER) or urgent care center (when necessary)
- Inpatient services (care received when you stay overnight in a hospital)
- Laboratory services (blood work, screenings)
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)
- Durable medical equipment (Durable medical equipment or DME includes medical equipment and supplies for things like hospital beds, crutches, wheelchairs and oxygen tanks)

Take a closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand how our prescription drug plans work and the choices you have when it comes to selecting and paying for these medications. Always talk to your doctor first about which medication is right for you.

Select drug list (Drug formulary)

All of our prescription drug plans have a formulary, called the Select Drug List. The Select Drug List is not a complete list, but is simply a list of the most commonly used FDA-approved drugs that your plan covers.

Prescription drug tiers

Every drug on the Select Drug List is assigned to a certain tier (or level) based on cost, availability of over-the-counter alternatives, clinical information and certain drugs used to treat the same or similar condition. The drug list tells you what tier your drug is in and related details on coverage. What you pay for your prescription depends, in part, on which tier your drug is in. For example, Tier 1 usually includes preferred generic drugs with the lowest cost to you. As the tier number increases, the drugs in that tier generally cost you more. If your drug is in a higher tier, you may want to speak with your doctor to find out if one of the drugs covered in a lower tier will work for you.

You can save even more money with home delivery pharmacy

Anthem wants to help lower the cost of prescription drugs, improve overall health and deliver top-notch customer service. We're here to help you understand and manage medicines used to treat a wide variety of conditions.

With our plans, you'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). These drugs are used for conditions like high blood pressure and high cholesterol. If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

Home delivery is convenient and safe

- You get up to a 90-day supply for non-specialty drugs
- Drugs are delivered straight to your door — with free standard shipping
- You can order refills your way – online, using our mobile app, by phone or by mail
- Many safety and high-level quality checks help make sure you get the right medicine in the right dose

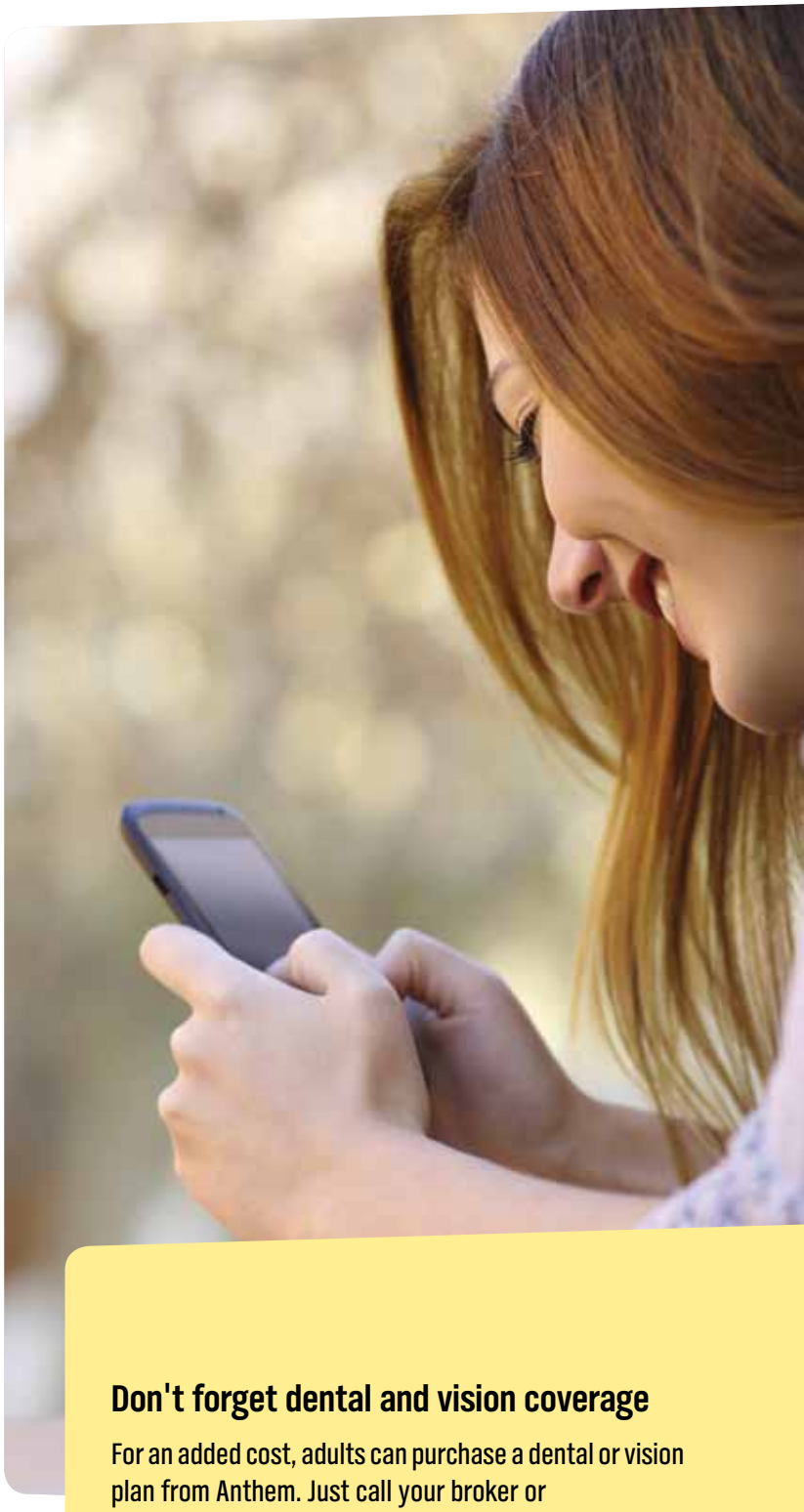
Manage your prescription drug benefits from your smartphone

Just by going to your health plan's mobile app, you can easily take advantage of our handy pharmacy tools on the go. With the click of a button you can:

- Locate a pharmacy
- Price a medication
- Switch from retail to home delivery
- Order a refill
- Check order status
- And more!

For more information, go to anthem.com:

- To find out if your medication is covered, take a look at our drug list at www.anthem.com/NVSelectdrugtier4.
- To learn more about pharmacy processes (such as prior authorization, step therapy, quantity limits, dose optimization), check out the FAQs at Customer Support > FAQs > FAQ Categories > Pharmacy.
- To see if your pharmacy is in our network, visit our Find a Doctor tool.



Don't forget dental and vision coverage

For an added cost, adults can purchase a dental or vision plan from Anthem. Just call your broker or Anthem authorized representative or go online to anthem.com for details.

See a term you're not familiar with? Check out our Glossary in the back of this brochure.

Choose the doctors and hospitals you know and trust

At Anthem, our goal is to work with doctors, hospitals and other health care providers who will give you quality care at a fair cost. Our Pathway and Pathway PPO networks include:

- Doctors and hospitals
- Emergency and urgent care centers
- Labs
- Durable medical equipment providers (includes retail and online stores)
- Mental health providers

Take care of yourself with no-cost in-network preventive care

Anthem's preventive care coverage options give you access to any of our in-network doctors, so you pay nothing out of pocket. Stay in control of your health care and your finances with $0 deductible, $0 copay and $0 added cost to you for covered preventive services received in our network.[1]

[1]Nationally recommended preventive care services received from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Stay in control of quality and costs with our easy-to-use online tools

Anthem offers a range of ways to get the information you need. From our website to cost and quality comparison tools to our mobile app that lets you find a doctor from the palm of your hand, we help make sure you have everything you need to make the best health care decisions for you and your family. With our website, you can:

- Get an idea of what is and isn't covered by your plan with an easy-to-understand breakdown of your benefits summary.
- Get instant access to your recent claims and coverage details.
- Know your costs before having certain procedures with cost estimates using our out-of-pocket cost calculator.

Find a Doctor

Want to make sure your doctor is in our network? Need to find a new doctor or specialist? No problem! Our online Find a Doctor tool helps you find doctors, hospitals, pharmacies and other specialists in your area — and shows whether they are cost-saving network providers.

Log on to anthem.com anytime or download our mobile app right to your phone, so you can search for doctors when you're on the go. When using the Find a Doctor tool, be sure to include the plan network (Pathway or Pathway PPO) as search criteria for the plan you are considering.

LiveHealth Online

When you or a family member is feeling under the weather, life doesn't wait for you to feel better. Good news is, with LiveHealth Online, you get medical care right when you need it. No appointments, no driving and no waiting at an urgent care center.

LiveHealth Online lets you connect with a doctor through your mobile device or a computer with a webcam. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections and allergies. It's faster, easier and more convenient than a visit to an urgent care center.

LiveHealth Online gives you peace of mind with:

- Immediate access to your choice of doctors.
- Secure and private video chats with board-certified doctors.
- Prescriptions sent directly to your pharmacy, if needed.[2]

After you're an Anthem member, enroll — download the LiveHealth Online app or go to livehealthonline.com!

Note: LiveHealth Online is currently only available in English.

Vitals health survey

Vitals makes it easy for you to see what other patients have said about the doctors and hospitals you may be thinking about using. Hearing what other patients' experiences were like can help you make more informed health care decisions about your own care. You can also share your experience with others by reviewing your doctor online!

Cost and quality information with Estimate Your Cost

Save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to compare quality and safety.

SpecialOffers discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids and services, fitness center memberships, Jenny Craig® and Weight Watchers® weight-loss programs and more. To view all discounts, log in at anthem.com and click on Discounts located on the Main Overview page.

Register at anthem.com for online access

Once you're a member, you'll want to register to get online access to your benefits. It's the information you need to make an informed decision – all in one place.

To register, type anthem.com in the web browser address field and click **Register Now** on the top right-hand side of your screen in the member log in area.

Don't miss out on these great tools! Be sure to register at anthem.com.

Take charge of your health with our health and wellness programs

Your health goals and needs are as unique as you are. That's why Anthem gives you access to programs that help you meet your personal goals and live your life to the fullest.

Get help from nurses 24/7

Day or night, you can talk to a registered nurse about your health concerns. Whether it's a question about allergies, the flu or choosing between the ER or urgent care, our nurses are there to give support. Going to the right place when you're not feeling well can save you time and money.

Supporting you when you have a larger health problem

Your health is our top priority. If you have a chronic or complex health problem, our Care Management Support program may be able to help. A case manager may call you to see how we can help you manage your health concerns. Our case managers can provide you with helpful information and offer emotional support services, if needed.

MyHealth Advantage

We're always looking for ways to help you live a healthier life and save money. That's why we review your medical and pharmacy history. If we find a way we think you can improve your health or save money, you'll get a MyHealth Note in the mail.

Access coverage — no matter where you are in the U.S. or worldwide — with BlueCard®

When you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to happen. The good news is all of our plans cover emergency and urgent care in every state through the Blue Cross and Blue Shield Association's BlueCard® Program. This means you and your family have emergency and urgent care coverage from coast to coast.

Our PPO plans also include additional coverage for non-emergency care when you visit participating BlueCard providers in the U.S. and when you travel outside the U.S. You have the choice to see any provider you wish, but your benefits cover more when you use participating BlueCard providers and hospitals.

Find the plan that's right for you

Choosing the right health care coverage is an important decision. Before you choose a plan, consider these tips. And remember, your broker or Anthem authorized representative is here to answer any questions.

Plan ahead

- **Make sure the plan will meet your health care coverage needs**. Think about how often you see doctors and specialists. What prescription medications do you take regularly?
- **If staying with your current doctors is important**, see if they're in our network by using our online Find a Doctor tool at anthem.com. Seeing in-network doctors can save you a lot of money on your health care.
- **Figure out your family's budget for coverage**. Some people would prefer to pay more in premium each month and less out of pocket each time for services like doctors' visits or lab work. Plans may offer different deductible, coinsurance and copay options so you can choose the level of cost sharing that meets your health care coverage needs and budget.
- **Review your plan options.** We offer plans to fit your health care coverage needs — and your budget. They are split into three different levels — Bronze, Silver and Gold. Your costs and coverage increase with each level.
  - *Bronze* - With a Bronze plan, you pay less for your monthly premium but you pay more when you get care. You have broad benefits with deductibles, copays and coinsurance that may be higher than the other plans.
  - *Silver* - Silver plans still have low monthly premiums but you pay less when you get care. However, the monthly premium is higher than a Bronze plan.
  - *Gold* - With a Gold plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Bronze and Silver plans.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. An HSA is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. Talk to your financial advisor about potential tax advantages.

Explore your options if you need help paying for coverage

The Affordable Care Act requires you to have health care coverage unless you qualify for an exemption. In addition, you may qualify for premium tax credits to help lower the cost of your monthly premium. You may also qualify for cost-sharing subsidies on Silver plans purchased on the Exchange, which can reduce the amount you pay for health care services. Or you may be eligible for your state's Medicaid program. The amount and type of financial help you could receive is based on your income, family size and health care expenses where you live.

- **See if you qualify to get help paying for your health insurance.** Before you choose a plan, it's a good idea to find out if you qualify to get help paying for your health insurance. If you do qualify, it may make more sense for you to choose an Anthem plan available through Nevada Health Link. Whether you choose an Anthem plan offered through Nevada Health Link or direct through Anthem, we have great plan options for you.

When you can purchase a plan

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs November 15, 2014 through February 15, 2015. The annual open enrollment period may vary from year to year, so you should check with your broker or Anthem authorized representative for more information.

Not sure what something means? See the Glossary in the back of this brochure.

When certain events occur in life, you can enroll in a plan

There are a lot of life events — from having a baby to moving to a new state — that may allow you to change your health plan during a **special enrollment period**. These are called "qualifying events." If you've had a change in your coverage, family or income that qualifies, you can shop for a new health plan without waiting for the next open enrollment period.

Let us know if you're:

- Losing coverage at work
- Getting married or divorced
- Having a baby or adopting a child
- Turning 26 and no longer covered under your parents' plan
- Experiencing other changes in your coverage, family or income
- Moving soon or just moved

Don't wait too long. Most people have only 60 calendar days after a qualifying event to enroll in a new plan. You'll need to show proof of the qualifying event.

Check with your broker or Anthem authorized representative for effective date options and guidelines around enrollment during other times of the year.

For plans off the exchange without a qualifying event

You will be able to enroll in an off exchange plan outside of the open enrollment period without a qualifying event. In all instances, Anthem reserves the right to request additional documentation to confirm eligibility. Your effective date may be delayed to the first of the month following a 90-day waiting period from when the application is received.

Avoid tax penalties

When you put off enrolling in a health plan, you may have to pay a penalty unless you qualify for an exemption. Penalties are based on your pay and increase each year. So, for example, by 2016 the penalty for a family of four with a household income of $70,000 could be as much as $1,750. And the penalty amounts will continue to go up in the future.

Ready to enroll in a plan? We can help!

Your broker or Anthem authorized representative is available to make enrolling as easy as possible for you. You can also apply online at anthem.com.

Follow these easy steps to enroll in one of our health plans

You and your family can receive all of the benefits of the Affordable Care Act. All you have to do is enroll. You may have heard it's hard to do, but it's really not and we're here to help you every step of the way.

What you'll need

Before you begin the enrollment process, be sure to have these handy:

- Employer and income information for every member of your household who needs coverage (for example, pay stubs or W-2 forms)
- Policy numbers and insurer names for any current health insurance plans covering members of your household
- Information about every job-based health insurance plan for which you or someone in your household is eligible

How to enroll in one of our Anthem plans

- Call your broker or Anthem authorized representative to enroll or learn more about the health care plans offered by Anthem.
- Visit our website at anthem.com and apply online.

Save money by making smart choices

- ***Save money on prescriptions with home delivery*** **-** When you use our home delivery pharmacy instead of a retail pharmacy, you'll save on drugs you take on a regular basis for a long time (e.g., maintenance medicines). These drugs are used for conditions like high blood pressure and high cholesterol. You can usually get a 90-day supply of non-specialty drugs for less than you would at a retail pharmacy, and standard shipping is free.

- ***Save time and money with an urgent care center or retail health clinic*** - You may save money - and usually lots of time - by going to places other than the emergency room (ER) when you need care for something other than an emergency. If you need care - and you're certain it's not a real emergency - the Find a Doctor tool at anthem.com can help find care alternatives to the ER like, urgent care centers, walk-in doctors' offices and retail health clinics.

- ***Using in-network doctors can help you save -*** When you need care, you will get the best value by visiting **in-network** doctors, hospitals or other health care providers. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you're paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

  Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with Anthem to provide services at a negotiated rate. **Our health maintenance organization (HMO) plans do not offer out-of-network benefits (with the exception of emergency and urgent care or when we authorize care)**. This means you will pay the entire cost for any service you get from **out-of-network** providers. **With our preferred provider organization (PPO) plans, you have the choice to visit out-of-network doctors or hospitals, but your share of the costs may be greater.**

  To find out if your current health care provider is in our network, visit our Find a Doctor tool on anthem.com.

- ***The doctors you can see -*** When you choose one of our health plans, you have the freedom to see any in-network doctor you choose. It's also a good idea to have a primary care physician (PCP) for things like checkups and health issues that need ongoing care. With our *PPO* plans, you're not required to pick one. However, with our *HMO* plans, you pick one of our in-network PCPs who helps to coordinate your care. **When you need to see other doctors, a referral from your PCP is not required.**

- ***Guest Membership/Away From Home Care when temporarily living out of state -*** With our *health maintenance organization (HMO) plans*, you or any of your covered dependents who will be away from home (and outside of your health plan's service area) for more than 90 days, can apply for a guest membership (also known as Away From Home Care) to one of our affiliated Blue Cross and Blue Shield plans in that area.

  A guest membership will allow you to become a "guest" of that other plan and take advantage of the benefits and coverage it provides. Guest membership comes in handy when students go to college in another state. Guest membership is not available in all areas.

- ***SpecialOffers discounts on health-related products and services -*** When you're a member, you can save money on all kinds of products and services that can help you live a healthy life. To view all discounts, log in at anthem.com and click on Discounts located on the Main Overview page.

- ***Make your health care dollars work harder with a Health Savings Account -*** A Health Savings Account (HSA) is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post-tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. HSA-compatible health care plans work with or without this savings account, the choice is yours. Plan choices that are HSA-compatible include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you and check out the insert from our preferred banking partner, BenefitWallet™.

Not sure what something means? See the Glossary in the back of this brochure.

Helping you understand how your health care plan works

Health care coverage can help protect you against the high costs of care. With most health care coverage, you pay a monthly fee called a premium; then, you share some of the cost of covered care with the company that provides your coverage. With Anthem, you can choose the level of cost sharing that works best for your health care needs and budget.

Here's an example: *Meet John*

John's story is only an example of how health plans work. John is not a real person and the example below is for illustrative purposes only. Be sure to look at the benefits for each of our plan choices for specific information.

John's health plan has the following benefits:

- $35 copay for doctor visits - $2,000 deductible - 30% coinsurance - $5,000 out-of-pocket limit

After injuring his knee in a soccer game, John calls his doctor. He chooses providers in our network, which saves him the most money. By choosing providers in our network, John gets lower negotiated rates (meaning, discounted prices). In the following examples, you'll see what John paid and why it's important to have health insurance.

Copay (Copayment)

On some plans you pay a fixed dollar amount for certain services when you get them. For example, when you see a doctor, you may be asked to pay a $35 copay.

Let's take a closer look at John's doctor's visit copay:

- *Doctor visit cost (without insurance):* $200
- Anthem's *negotiated rate:* $140
- Anthem *pays:* $105
- *What John paid:* $35 (his plan's copay for doctor office visit)

Deductible

You pay this amount for covered medical services each calendar year which means January 1 through December 31. Covered services that apply to the deductible may include lab work, X-rays, anesthesia and surgeon fees. (Covered preventive services start before the deductible is met.) Your deductible starts over each calendar year.

Please note:
For non-HSA plans, each family member has an individual deductible and out-of-pocket limit. The family deductible and out-of-pocket limit can be satisfied by two or more members. No one person can contribute more than his or her individual deductible or out-of-pocket limit. For HSA-compatible plans, either one or more family members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket limit can be met by either one or more members. Once the limit is met, no additional coinsurance will be required for the family for the remainder of the calendar year.

Here's what happens next when John's doctor orders an approved MRI of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- Anthem's *negotiated rate:* $1,000
- *What John paid:* $1,000 (John's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- Anthem's *negotiated rate:* $35,000
- *What John paid:* $1,000 (John's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

Coinsurance

Once you've met your deductible, Anthem starts paying a portion of claims. The health care bills that remain are shared between you and Anthem. Your coinsurance is the percent that you must pay for a covered service per calendar year. Having met his deductible, John's coinsurance begins.

Let's check in to see what John will be paying.

- *Coinsurance:* 30% (30% of $34,000 = $10,200)
- *What John paid:* $2,965 (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)

Out-of-pocket limit

The most you pay during a policy period before your health insurance begins to pay at 100% (of the maximum allowed amount). The amounts you pay for your deductible, coinsurance and copay are typically what make up your out-of-pocket limit. Once you meet your out-of-pocket limit, we pay 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.

John has met his out-of-pocket limit and the remaining surgery costs are paid by Anthem.

- Anthem *pays:* $31,035
- *Out-of-pocket limit:* $5,000 (John paid: $35 copay for doctor office visit + $2,000 deductible + $2,965 coinsurance)

Summary

John paid far less out-of-pocket because he had health care coverage. If John had used a provider outside of our network, depending on his plan, he might not have had coverage or would have had to pay much more.

- *Total for doctor visit, MRI and surgery (without health insurance):* $51,700
- *Total* Anthem *paid after discounts:* $31,140
- *Total John paid:* $5,000

Glossary

Affordable Care Act (also known as health care reform)
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

BlueCard
BlueCard is a national program that lets members of one Blue Cross and Blue Shield (BCBS) plan access health care services while traveling in another BCBS plan's service area. Available services may be limited with these plans. To find doctors and hospital in the BlueCard program, have your ID card handy and visit the BlueCard Doctor and Hospital Finder at bcbs.com.

Brand-name drugs
These are drugs that are developed by a company that holds the patents and rights to sell them.

Coinsurance
The amount that you pay for health care services. This is usually a certain percentage of the cost of health care services after the deductible has been paid. *Example*: A health plan pays 80% of the maximum allowed amount for the service and you pay the remaining 20%. This is referred to as the coinsurance.

Copay (also copayment)
A fixed fee that you pay out-of-pocket for each visit to a health care provider. For example, if your copayment is $30, then you pay $30 when you see your doctor — usually at the time you receive treatment. The amount of your copayment sometimes varies by the type of health care service you receive.

Deductible
This is a set amount that you pay before your plan starts paying for covered services. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Note: You must meet your deductible every calendar year even if your effective date (the date your coverage begins) is later than January 1. The calendar year runs from January 1 through December 31.

Exchange (also known as the Marketplace)
A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan and enroll in coverage. The name of the Exchange in your state is Nevada Health Link.

Exclusions
Exclusions are health care goods and services that are not covered by your health plan. You can find a list of exclusions in your plan materials.

Formulary (also Select Drug List)
This is a list of the most commonly used drugs your plan covers. The list tells you what tier your drug is in and related details on coverage.

Generic drugs
Generics are copies of brand-name drugs with the same active ingredients. Most generics usually cost you less money than their brand-name counterparts.

Health Savings Account (HSA)
A HSA is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions.

High-deductible health plan (HDHP)
A HDHP has lower premiums and higher deductibles than a traditional health plan.

In-network/Network
Refers to providers who participate in the plan's network.

Out-of-network/Non-network
Refers to providers who do not participate in the plan's network.

Out-of-pocket limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the maximum allowed amount. This limit never includes your premium, balance-billed charges, or health care your insurance or plan doesn't cover.

Premium
The amount that must be paid for your health insurance or plan. You usually pay it monthly, quarterly or yearly.

Premium tax credit
A fixed amount or percentage of a member's premium provided as a tax credit to help low-income individuals buy health insurance on the Exchange. You can use it to buy any plan offered on the Exchange in your state.

Prescription drug tiers
Every drug on the formulary (Select Drug List) is in a cost-sharing tier. The tier level determines what you will pay for your prescription.

Primary Care Physicians (PCPs)
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Provider
A doctor, hospital, licensed health care facility, program, agency or health care professional that delivers health care services.

Learn more

You've read about a lot in this brochure. If you'd like to learn even more, here is a list of helpful resources:

- ***Health care reform hub***
  makinghealthcarereformwork.com (visit anthem.com > Resources > select Health Care Reform)
- ***Subsidy Estimator***
  kff.org/interactive/subsidy-calculator/
- ***www.nevadahealthlink.com***
- ***Will I qualify to save on monthly premiums?***
  www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/
- ***Injury Facts 2011 Edition***, National Safety Council
  nsc.org/news_resources/injury_and_death_statistics/Documents/Injury-Facts-Report.pdf
- ***The Unsustainable Cost of Health Care***
  Social Security Advisory Board ssab.gov/Documents/Summary-HealthCare.pdf
- ***The Henry J. Kaiser Family Foundation***
  statehealthfacts.org
- ***National Hospital Discharge Survey***
  Centers for Disease Control and Prevention
  cdc.gov/nchs/nhds.htm
- ***Costhelper***
  health.costhelper.com/broken-leg.html

Anthem BlueCross BlueShield

Get help today!

Call your broker or Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

We want you to be satisfied

After you enroll in a plan offered by Anthem, you'll receive a Certificate that explains the exact terms and conditions of coverage, including the Certificate's exclusions and limitations. You will have 10 days to examine your Certificate's features. During that time, if you are not fully satisfied, you may cancel your Certificate and your premium will be refunded, less any claims that were already paid.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the Certificate may be continued in force or discontinued. For more complete details, including what's covered and what isn't:

- Review the Certificate.
- Call your broker or Anthem authorized representative.
- Go to anthem.com.

To access a Summary of Benefits and Coverage (SBC), please visit www.sbc.anthem.com > Select Member.

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance. Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a premium tax credit or subsidy to help pay for their health insurance. You can only get financial help if you are eligible and buy your individual health coverage through Nevada Health Link.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

1. Nationally recommended preventive care services received from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
2. As legally permitted in certain states.

SpecialOffers is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

A high deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional. BenefitWallet is an independent corporate entity that provides banking administration on behalf of Anthem Blue Cross and Blue Shield.

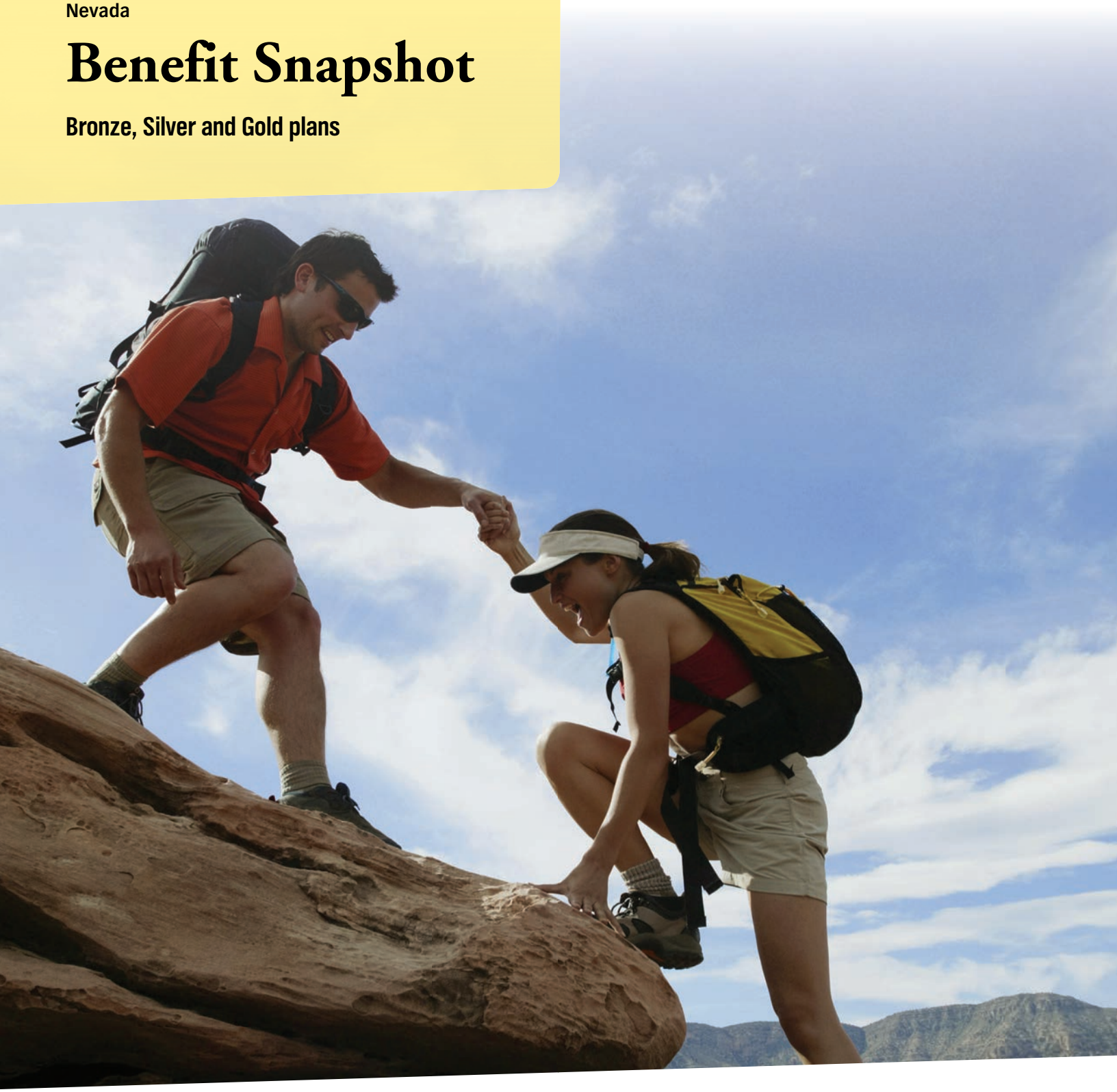
Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Anthem BlueCross BlueShield

Individual and family health benefit plans for Nevada

Benefit Snapshot

Bronze, Silver and Gold plans



Benefit Snapshot

Anthem Blue Cross and Blue Shield (Anthem), through its subsidiary company, HMO Colorado, Inc., dba HMO Nevada, is pleased to offer individual plan choices. Below is a listing of them, including a sample of commonly used benefits and how they are covered under each plan. ***Cost-share and benefit information in this snapshot is for in-network covered services unless otherwise noted.*** When filling out an application, be sure the entire plan name on the application matches the plan you're applying for.

Our plan names include the following elements: Anthem + metal level + network name + product type + deductible/coinsurance + (for HSA) (Example: Anthem Bronze Pathway HMO 5000/40%). Elements in parenthesis are used when appropriate. If you need more information about a benefit that is not listed here, please check with your broker or Anthem authorized representative. You can also view and compare plans on anthem.com.

	Anthem Bronze Pathway HMO 5000/40%	Anthem Bronze Pathway HMO 5750/30%	Anthem Bronze Pathway HMO 6150/20%	Anthem Bronze Pathway HMO 25% for HSA
Network Name[1]	Pathway	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?[1]	No	No	No	No
Individual Deductible[2] *(Family[3] = 2 x Individual amount)*	$5,000	$5,750	$6,150	$3,600
Individual Out-of-pocket Limit[2] *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,600	$6,600	$6,350	$6,450
Coinsurance[2]	40% coinsurance	30% coinsurance	20% coinsurance	25% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	$50 copay per visit for first 2 office visits, then deductible and 40% coinsurance	$45 copay per visit for first 2 office visits, then deductible and 30% coinsurance	$40 copay per office visit, unlimited	Deductible, then 25% coinsurance
Office Visit: Specialist	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 40% coinsurance	Deductible, then $50 copay and 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then $50 copay and 25% coinsurance
Emergency Room Care	Deductible, then $200 copay and 40% coinsurance	Deductible, then $200 copay and 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then $200 copay and 25% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then $500 copay and 25% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Retail Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Combined with medical deductible
Retail Pharmacy Tier 1[5,6]	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	$20 copay	Deductible, then 25% coinsurance
Retail Pharmacy Tier 2[5,6]	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	$50 copay	Deductible, then 25% coinsurance
Retail Pharmacy Tier 3[5,6]	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Retail Pharmacy Tier 4[5,6]	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Dental[7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Physical, Occupational and Speech Therapy[8] *(limit of 120 combined inpatient/outpatient visits per year)*	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance

More about our plans...

[1]**Pathway PPO** plans also include out-of-network benefits. **Pathway** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with our **Pathway** plans.

[2]Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.

[3]Our plans, with the exception of HSA plans, have **embedded family deductibles** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. Our HSA plans have **non-embedded family deductibles** where all family members share one common family deductible.

[4]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[5]**Retail pharmacy** is limited to a 30-day supply.

[6]**Prescription drugs:** You'll use our home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

[7]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[8]**Physical Therapy, Speech Therapy and Occupational Therapy** services, whether for rehabilitation or habilitative purposes, are limited to a combined maximum of 120 visits/days, Inpatient and Outpatient combined, per benefit period.

	Anthem Bronze Pathway HMO 0% for HSA	Anthem Bronze Pathway PPO 4500/20%	Anthem Bronze Pathway PPO 6200/30%	Anthem Bronze Pathway PPO 20% for HSA
Network Name[1]	Pathway	Pathway PPO	Pathway PPO	Pathway PPO
Plan includes out-of-network coverage?[1]	No	Yes	Yes	Yes
Individual Deductible[2] *(Family[3] = 2 x Individual amount)*	$6,300	$4,500 / $9,000 In-network / Out-of-network	$6,200 / $11,100 In-network / Out-of-network	$4,000 / $8,000 In-network / Out-of-network
Individual Out-of-pocket Limit[2] *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,300	$6,600 / $13,500 In-network / Out-of-network	$6,600 / $16,650 In-network / Out-of-network	$6,450 / $12,000 In-network / Out-of-network
Coinsurance[2]	0% coinsurance	20% / 50% coinsurance In-network / Out-of-network	30% / $60% coinsurance In-network / Out-of-network	20% / 50% coinsurance In-network / Out-of-network
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	Deductible, then 0% coinsurance	$35 copay per visit for first 2 office visits, then deductible and 20% coinsurance	$45 copay per visit for first 2 office visits, then deductible and 30% coinsurance	Deductible, then 20% coinsurance
Office Visit: Specialist	Deductible, then 0% coinsurance	$60 copay per visit for first 2 office visits, then deductible and 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible then 0% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 30% coinsurance	Deductible, then $50 copay and 20% coinsurance
Emergency Room Care	Deductible, then 0% coinsurance	Deductible, then $200 copay and 20% coinsurance	Deductible, then $250 copay and 30% coinsurance	Deductible, then $200 copay and 20% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then 0% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $350 copay and 30% coinsurance	Deductible, then $500 copay and 20% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible	Combined with medical deductible	Combined with medical deductible
Retail Pharmacy Tier 1[5,6]	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Tier 2[5,6]	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Tier 3[5,6]	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Tier 4[5,6]	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Dental[7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Physical, Occupational and Speech Therapy[8] *(limit of 120 combined inpatient/outpatient visits per year)*	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance

More about our plans...

[1]**Pathway PPO** plans also include out-of-network benefits. **Pathway** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with our **Pathway** plans.

[2]Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.

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[7]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[8]**Physical Therapy, Speech Therapy and Occupational Therapy** services, whether for rehabilitation or habilitative purposes, are limited to a combined maximum of 120 visits/days, Inpatient and Outpatient combined, per benefit period.

	Anthem Silver Pathway HMO 1750/20%	Anthem Silver Pathway HMO 2250/10%	Anthem Silver Pathway HMO 2250/20%	Anthem Silver Pathway HMO 2250/30%
Network Name[1]	Pathway	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?[1]	No	No	No	No
Individual Deductible[2] *(Family[3] = 2 x Individual amount)*	$1,750	$2,250	$2,250	$2,250
Individual Out-of-pocket Limit[2] *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,350	$6,350	$6,350	$6,000
Coinsurance[2]	20% coinsurance	10% coinsurance	20% coinsurance	30% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	$35 copay per visit for first 2 office visits, then deductible 20% coinsurance	Deductible, then 10% coinsurance	$35 copay per office visit, unlimited	$35 copay per visit for first 2 office visits, then deductible and 30% coinsurance
Office Visit: Specialist	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 30% coinsurance
Emergency Room Care	Deductible, then $200 copay and 20% coinsurance	Deductible, then $200 copay and 10% coinsurance	Deductible, then $200 copay and 20% coinsurance	Deductible, then $200 copay and 30% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 30% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Retail Pharmacy Deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible
Retail Pharmacy Tier 1[5,6]	$15 copay	$15 copay	$15 copay	$15 copay
Retail Pharmacy Tier 2[5,6]	$40 copay	$40 copay	$40 copay	$40 copay
Retail Pharmacy Tier 3[5,6]	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Retail Pharmacy Tier 4[5,6]	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Dental[7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Physical, Occupational and Speech Therapy[8] *(limit of 120 combined inpatient/outpatient visits per year)*	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance

More about our plans...

[1]**Pathway PPO** plans also include out-of-network benefits. **Pathway** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with our **Pathway** plans.

[2]Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.

[3]Our plans, with the exception of HSA plans, have **embedded family deductibles** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. Our HSA plans have **non-embedded family deductibles** where all family members share one common family deductible.

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[7]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[8]**Physical Therapy, Speech Therapy and Occupational Therapy** services, whether for rehabilitation or habilitative purposes, are limited to a combined maximum of 120 visits/days, Inpatient and Outpatient combined, per benefit period.

	Anthem Silver Pathway HMO 2500/10%	Anthem Silver Pathway PPO 2250/20%	Anthem Silver Pathway PPO 3500/0%	Anthem Gold Pathway HMO 1100/10%
Network Name[1]	Pathway	Pathway PPO	Pathway PPO	Pathway
Plan includes out-of-network coverage?[1]	No	Yes	Yes	No
Individual Deductible[2] *(Family[3] = 2 x Individual amount)*	$2,500	$2,250 / $4,500 In-network / Out-of-network	$3,500 / $7,000 In-network / Out-of-network	$1,100
Individual Out-of-pocket Limit[2] *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,350	$6,600 / $6,750 In-network / Out-of-network	$4,500 / $10,500 In-network / Out-of-network	$6,000
Coinsurance[2]	10% coinsurance	20% / 50% coinsurance In-network / Out-of-network	0% / 30% coinsurance In-network / Out-of-network	10% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	$45 copay per office visit, unlimited	$35 copay per office visit, unlimited	$45 copay per visit for first 3 office visits, then deductible and 0% coinsurance	$25 copay, per office visit unlimited
Office Visit: Specialist	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	$70 copay per visit for first 3 office visits, then deductible and 0% coinsurance	Deductible, then 10% coinsurance
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	0% coinsurance	Deductible, then 10% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 0% coinsurance	Deductible, then $50 copay and 10% coinsurance
Emergency Room Care	Deductible, then $200 copay and 10% coinsurance	Deductible, then $200 copay and 20% coinsurance	Deductible, then $200 copay and 0% coinsurance	Deductible, then $200 copay and 10% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 0% coinsurance	Deductible, then $500 copay and 10% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	0% coinsurance	Deductible, then 10% coinsurance
Retail Pharmacy Deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible
Retail Pharmacy Tier 1[5,6]	$15 copay	$15 copay	$15 copay	$15 copay
Retail Pharmacy Tier 2[5,6]	$40 copay	$40 copay	$40 copay	$40 copay
Retail Pharmacy Tier 3[5,6]	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance
Retail Pharmacy Tier 4[5,6]	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance
Dental[7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Physical, Occupational and Speech Therapy[8] *(limit of 120 combined inpatient/outpatient visits per year)*	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance

More about our plans...

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[5]**Retail pharmacy** is limited to a 30-day supply.

[6]**Prescription drugs:** You'll use our home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

[7]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[8]**Physical Therapy, Speech Therapy and Occupational Therapy** services, whether for rehabilitation or habilitative purposes, are limited to a combined maximum of 120 visits/days, Inpatient and Outpatient combined, per benefit period.

Anthem BlueCross BlueShield

Get help today!

Call your broker or Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the Certificate may be continued in force or discontinued. For more complete details, including what's covered and what isn't:

- Review the Certificate.
- Call your broker or Anthem authorized representative.
- Go to anthem.com.

To access a Summary of Benefits and Coverage (SBC), please visit www.sbc.anthem.com > Select Member.

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance. Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a premium tax credit or subsidy to help pay for their health insurance. You can only get financial help if you are eligible and you buy your individual health coverage through Nevada Health Link.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Your HSA: Convenience, savings and flexibility all rolled into one

Introducing BenefitWallet:

Setting up a Health Savings Account (HSA)

To realize your plan's full financial power, consider selecting a plan with an HSA account. The portability and tax savings of an HSA account can add up fast.

We've joined with BenefitWallet®, A Xerox Solution, to integrate its HSA Solution into a selection of our plans. Setting up your account with BenefitWallet is easy. Plus, it comes with built-in advantages and conveniences like:

- A single Customer Service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account
- Mobile App for iPhone®, iPad® and AndroidTM devices and mobile access from any mobile device
- Health Topics encyclopedia of more than 1,500 ailments
- Medication Advisor for drugs and pharmacy identifier
- Treatment Cost Advisor for common medical conditions
- FDIC-insured checking account with the custodian, The Bank of New York Mellon (BNY Mellon)

Of course, if you'd rather use another financial institution for your account, that's fine, too.

You're only one checkmark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a *Welcome Kit* to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

A closer look

HSA Welcome Kit

If you make the selection on your application form, your HSA will automatically be set up — no set-up fee required, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using and opening your account. A separate application for your account is only required if you choose an HSA administrator other than BenefitWallet.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $1,000 HSA balance. Investment options include a number of mutual families. Once you're ready to invest, login to your account and select "Investments" from the Quick Links menu or contact the BenefitWallet Service Center at **866-686-4798**, Monday through Friday, from 8 a.m. to 11 p.m. ET, for more information or to begin investing.

Debit cards, checkbooks and online banking

Use your VISA debit card, your HSA checkbook or online bill pay (provided by BenefitWallet) to pay your health care provider or pharmacy directly for eligible medical expenses — or to reimburse yourself for qualified medical expenses paid out of pocket.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your deposit slip. Deposit slips can be found at the back of the checkbook, online through the Help Center or through the BenefitWallet Service Center. Or, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statements

Regularly, you'll receive an electronic statement from BenefitWallet that shows all your account activity. Your monthly statement is free if you open your account electronically. For an additional fee of $1.25 per month, you can receive a paper statement. Please go to anthem.com or call your dedicated Customer Service line to learn how to elect this option. You'll also receive *IRS 1099* and *IRS 5498* forms from BNY Mellon near tax time to help with tax preparation.

BenefitWallet HSA fee and rate schedule

A *Deposit Agreement* and *Disclosure Statement*, along with a *Rate and Fee Sheet* will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As appealing as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	$2.95
First two debit cards, Debit card transactions, Check writing, Online bill pay, Electronic transfers	no charge
ATM transactions	$2
Card replacement Duplicate check	$5
Check reorder	$10
Nonsufficient funds	$25
Periodic paper statement	$1.25

This is what the IRS requires if you want to open a Health Savings Account:

- **You must be covered by an HSA-compatible, high-deductible health plan.**
- **You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.**
- **You cannot be covered by any other medical plan that is not an HSA-compatible, high-deductible health plan.**
- **You cannot be enrolled in Medicare.**
- **You cannot be claimed as a dependent on another individual's tax return.**
- **If you are a veteran, you may not have received veteran's benefits within the last three months.**
- **You cannot be active military.**

BenefitWallet is an independent corporate entity that provides banking administration on behalf of Anthem Blue Cross and Blue Shield.
Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc.; HMO plans administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Coverage Details for Nevada

Anthem BlueCross BlueShield

Things you should know before you buy these plans...

Anthem Bronze Pathway HMO plans 5000/40%, 5750/30%, 6150/20%, 25% for HSA and 0% for HSA; Anthem Bronze Pathway PPO plans 4500/20%, 6200/30% and 20% for HSA; Anthem Silver Pathway HMO plans 1750/20%, 2250/10%, 2250/20%, 2250/30% and 2500/10%; Anthem Silver Pathway PPO plans 2250/20% and 3500/0%; Anthem Gold Pathway HMO 1100/10%; and Anthem Catastrophic Pathway HMO 6600/0%

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Eligibility

You can apply for coverage for yourself or with your family. You must be a resident of the State of Nevada and not entitled to or enrolled in Medicare. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and members may change benefit plans at that time.

Special Enrollment and Changes Affecting Eligibility

In addition to open enrollment, an individual can enroll during the special enrollment period. This is a period of time in which eligible individuals or their dependents can enroll after the open enrollment, typically due to an event such as marriage, birth, adoption, or other qualifying events as defined by law.

Depending on the event which triggers the special enrollment period, coverage may be effective as of the date of the qualifying event.

In all instances, we reserve the right to request additional documentation to confirm eligibility.

If you need coverage outside of the annual open enrollment period or the special enrollment period, you can apply for an off-exchange plan, but your effective date may be the first of the month following a 90-day waiting period from the date the application is received.

Effective Date of Coverage

The earliest effective date for the annual open enrollment period is the first day of the following calendar year. The actual effective date is determined by the date Anthem or HMO Nevada receives a complete application with the applicable premium payment.

Guaranteed Renewable

Coverage under the Certificate is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. As a member, you may renew the Certificate by payment of the renewal premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria, as set forth in the Certificate, continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of the Certificate; and
3. Membership has not been terminated by Anthem or HMO Nevada under the terms of your Certificate.

In-network Providers

In-network providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain covered services from providers located in the State of Nevada; however, the broadest benefits are provided for services obtained from a primary care physician (PCP), specialty care physician (SCP), or other in-network providers.

With our preferred provider organization (PPO) plans, you have the freedom to see any in-network doctor you choose. With our health maintenance organization (HMO) plans, you choose one of our in-network PCPs who helps to coordinate your care. When you need to see other in-network doctors, a referral from your PCP is not required.

Services you obtain from any provider other than a PCP, SCP or another in-network provider are considered a non-network service, except for emergency care or urgent care.

Out-of-network Providers

For HMO plans, services will only be covered services if rendered by providers located in the State of Nevada unless:

- The services are for emergency care, urgent care or ambulance services; or
- The services are approved in advance by Anthem.

Covered services which are not obtained from a PCP, SCP or another in-network provider or not an authorized service will be considered a out-of-network service. The only exceptions are emergency care and urgent care. In addition, certain services are not covered unless obtained from an in-network provider. See your Summary of Benefits.

For PPO plans, services will be covered services if rendered by out-of-network providers, but your share of the costs may be greater.

For services rendered by an out-of-network provider, you may be responsible for:

- The difference between the actual charge and the maximum allowed amount plus any deductible and/or copayments/coinsurance;
- Services that are not medically necessary;
- Non-covered services;
- Filing claims;
- Higher cost-sharing amounts

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for one of these plans. You can also find out where they are located and details about their license or training.

- See your Plan's directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or provider.

When using the Find a Doctor tool, be sure to include the plan network (Pathway or Pathway PPO) as search criteria for the plan you are considering.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member needs certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization Management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, does medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before you get medical care)

We may do a prospective review before a member goes to the hospital or has other types of services or treatment. Here are some types of medical needs that might call for a prospective review:

- A hospital visit;
- An outpatient procedure;
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans;
- Certain types of outpatient therapy, like physical therapy or mental health counseling;
- Durable medical equipment (DME), like wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical therapy or mental health therapy, home health care, durable medical equipment, a stay in a nursing home, mental health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

The retrospective or post-service review (done after you get medical care)

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are based

on standards of care in medical policies, clinical guidelines and the terms of your plan. As these may change, we review our preauthorization guidelines regularly. Preauthorization is also called "precertification," "prior authorization," or "pre-approval."

Here's how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who's in our network can help you get the most for your health care dollar.

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with an in-network doctor. If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Out-of-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website:
http://www.anthem.com/health-insurance/customer-care/faq.

Exclusions

This list includes some of the more common services not covered by these plans:

- Acupuncture
- Alternative or complementary medicine
- Artificial and mechanical hearts
- Breast reduction or augmentation
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in the Certificate
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Comfort and/or convenience items
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in the Certificate
- Educational services
- Experimental or investigative treatment
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Pharmacy, except as described in the Certificate
- Routine foot care
- Services we determine aren't medically necessary
- Sex transformation surgery
- Vein treatment - treatment of varicose veins or telanqiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes
- Vision, except as described in the Certificate
- Weight loss programs or treatment of obesity except as mandated
- Workers' compensation

Limitations

The specific limitations are spelled out in the terms of the particular plan, but some of the more common services limited by these plans are:

- Applied behavior analysis – 500 hourly sessions
- Therapy services (rehabilitation or habilitative)
  - Physical therapy, Speech therapy and Occupational therapy – limited to a combined maximum of 120 visits/days per member per year, Inpatient and Outpatient combined
- Home health care – 30 visits per year, combined with private duty nursing
- Skilled nursing facility – 100 days per year

To access a Summary of Benefits and Coverage (SBC), please visit www.sbc.anthem.com > Select Member.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the Certificate may be continued in force or discontinued. For more complete details, including what's covered and what isn't:

- Review the Certificate.
- Call your Anthem authorized representative.
- Go to anthem.com.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance. Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a premium tax credit to help pay for their health insurance. You can only get financial help if you are eligible and buy your individual health coverage through Nevada Health Link.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem authorized representative to request them.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Nevada
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross and Blue Shield (Anthem), premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 330-1217.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of January. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage, applications may be submitted up to 30 days in advance of the qualifying event date. Outside the Open Enrollment period and without a qualifying event, the applicant can enroll, but may be subject to a waiting period where permitted by law. Dependents cannot be added to or change between plans outside the Open Enrollment period or without a qualifying event.

Qualifying Events

Please check the type of enrollment or qualifying event:

- ☐ Open Enrollment;
- ☐ Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- ☐ Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;
- ☐ Marriage/Domestic Partnership;
- ☐ Birth or adoption or placement for adoption or appointment of guardianship;
- ☐ Moved to a new exchange service area or immigration status changed to lawfully present;
- ☐ Other Qualifying Event: _____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events).
- ☐ No qualifying event – when choosing this option, your effective date will be the 1st of the month following a 90 day waiting period.

Please provide the date of the qualifying event (which includes the date of Loss of Minimum Essential Coverage): _____

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If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application; or
- In the case of all other qualifying events, where the application is received between the first and the fifteenth day of the month, coverage shall become effective the first day of the following month. Where the application is received between the sixteenth and last day of the month, coverage shall become effective the first day of the second following month.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number* (required)
Home Address			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable)			
City	State	ZIP	
Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /	
Primary Phone Number	Secondary Phone Number	E-mail	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth / /	

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse's or your Domestic Partner's children (to the end of the calendar month in which they turn age 26). (List all dependents beginning with the eldest.)

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number* (required)	Relationship to Applicant
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? ☐Yes ☐No

If **NO**, who? _____

Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens? ☐Yes ☐ No

If **NO**, who?

_____

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐No

_____

Has any applicant used tobacco products 4 or more times per week, on average, excluding religious or ceremonial usage in the last 6 months? ☐ Yes ☐ No

If **YES**, who?

_____

Preferred written language? (Optional)	☐ English (ENG)	☐ Spanish (SPN)
Preferred spoken language? (Optional)	☐ English (ENG)	☐ Spanish (SPN)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a “Statement of Accountability”.

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan…then select ONE Individual Deductible/Coinsurance Option.

Total Family Deductible is two (2) times the amount shown.

☐ **Anthem Bronze Pathway HMO**
- ☐ $5,000/40% (1G40)
- ☐ $5,750/30% (1G42)
- ☐ $6,150/20% (1G48)

☐ **Anthem Bronze Pathway PPO**
- ☐ $4,500/20% (1G4B)
- ☐ $6,200/30% (1G49)

☐ **Anthem Silver Pathway HMO**
- ☐ $1,750/20% (1G52)
- ☐ $2,250/10% (1G2K)
- ☐ $2,250/20% (1G4U)
- ☐ $2,250/30% (1G4K)
- ☐ $2,500/10% (1G4W)

☐ **Anthem Silver Pathway PPO**
- ☐ $2,250/20% (1G4X)
- ☐ $3,500/0% (1G50)

☐ **Anthem Gold Pathway HMO**
- ☐ $1,100/10% (1G2Q)

☐ **Anthem Catastrophic Pathway HMO**
- ☐ $6,600/0% (1G2W)

HSA Plans

☐ **Anthem Bronze Pathway HMO 0% for HSA (1G44)**
☐ **Anthem Bronze Pathway HMO 25% for HSA (1G46)**
☐ **Anthem Bronze Pathway PPO 20% for HSA (1G4A)**

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

Please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (855) 854-1438. If you do not choose a PCP, then one will be selected for you.

Applicant	Primary Care Physician (PCP)	PCP ID	Current Patient	PMG/IPA ID*
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental Coverage

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health benefits to age** 19 **which are included in the medical plans above.**

Select All that Apply:

☐ Anthem Dental Family (1FU5) ☐ Anthem Dental Family Enhanced (1FU6)

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

Section G – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, who and reason:

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Anthem coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

I, the undersigned, understand that under the Anthem plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

- I understand that although Anthem requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
- I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is only eligible for coverage if: we have chosen to share one another's lives in an intimate and committed relationship of mutual caring; we desired by our own free will to enter into a domestic partnership; the NV Secretary of State has issued a Certificate of Registered Domestic Partnership to us; we share a common residence on at least a part time basis; he or she is mentally competent; he or she is at least 18 years old; is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else.
- ☐ By checking this box, I authorize and expressly consent that Anthem and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and underwriting, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Anthem customer service or online at www.anthem.com.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).
- As part of the W-9 Certification required by the Internal Revenue Service, I certify that the SSN number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

I give this authorization for and on behalf of any eligible dependents and myself if covered by. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem and me. I agree to abide by the terms of that contract.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE AFFORDABLE CARE ACT. ANTHEM AND I AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN OUR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT ANTHEM AND I ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

BEFORE COMMENCING ARBITRATION IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE VOLUNTARILY AGREEING TO HAVE ANY DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your Anthem-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: _____

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **X**				Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.		
Agent/Broker ID/TIN	Agency ID/Parent TIN	City	State	ZIP
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail		
GA (if applicable)		GA code (if applicable)		

Section J – Statement of Accountability

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:_____

I also translated and fully explained the "Significant Terms, Conditions, and Authorizations (TERMS)" and "Payment Method".

Translator Signature ***(Required)***	Date ***(Required)***
X	

I confirm that the application was interpreted on my behalf.

Applicant Signature ***(Required)***	Date ***(Required)***
X	

Language interpreted (e.g. Spanish): _____

Please mail this application to the following address:

Anthem Blue Cross and Blue Shield

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Payment Methods for Individual Applications – Nevada

Anthem BlueCross BlueShield

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa and MasterCard.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

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How to enroll

Sign up today for our dental and vision plans!

For Dental Prime plans:
Fill out a form online or by hand:

- Go to AnthemDentalAdmin.com.
- Or fill out and sign the appropriate form. Then give the form to your agent or mail it to us at:

  Dental Enrollment Department
  P.O. Box 1193
  Minneapolis, MN 55440-1193

For Anthem Dental Pediatric, Anthem Dental Family, Anthem Dental Family Enhanced plans:

Fill out and sign the form. Give your completed form to your agent or mail it to us at:

Dental Enrollment Department
P.O. Box 9041
Oxnard, CA 93031-9041

Anthem BlueCross BlueShield

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Anthem BlueCross BlueShield

Dental and vision coverage for your total health

47979NVMENABS Rev. 01/15

Anthem dental plans

We offer a variety of individual and family dental plan options to fit your needs and budget. These plans include:

- Dental Prime for Individuals and Families with optional Vision benefits.
- Anthem Dental Pediatric, Anthem Dental Family plans and Anthem Dental Family Enhanced

Health care reform

Essential health benefits include dental and vision

Pediatric dental is one of the 10 essential health benefits that are included in nearly all individual medical plans as of January 2014.

Consumers have the following purchase options if they need or want pediatric dental essential health benefits:

- A medical plan that has pediatric dental essential health benefits coverage.
- A stand-alone pediatric dental essential health benefits policy (Dental Pediatric plan).
- A stand-alone adult or family dental plan that includes pediatric dental essential health benefits coverage.

On exchange

If you're eligible for a subsidy to help pay for your health coverage and want to use it, you must get your medical plan through the state's health coverage exchange, which is an online marketplace to buy health coverage.

To learn more, visit your state's exchange website at nevadahealthlink.com.

Off exchange

If you aren't eligible for a subsidy, or if you're shopping for a dental or vision plan, you don't have to buy through the exchange. **You can still get coverage as before, through a broker or agent, or directly from an insurance company.**

Because there are rules for plans on the exchange, you might find that plans off the exchange offer more choices.

Our off-exchange products

Anthem Blue Cross and Blue Shield (Anthem) can help you get the dental and vision care you need — which can help you get a better handle on your total health. That's why many of our dental plans include exams, cleanings and X-rays covered 100%, and all of our vision plans include coverage for yearly vision exams.

The table helps you compare your plan choices. So you have many ways to get the smile you want and keep a healthy mouth.

	Anthem Dental Pediatric	Anthem Dental Family		Anthem Dental Family Enhanced		Dental Prime		
	Dependents age 18 and younger	*Dependents age 18 and younger*	*Adults age 19+*	*Dependents age 18 and younger*	*Adults age 19+*	*Plan A*	*Plan B*	*Plan C*
	In- and out-of-network							
Diagnostic and preventive services	No waiting period	No waiting period	No waiting period	No waiting period		No waiting period		
Cleaning, exams, X-rays	90%/70%	90%/70%	100%/50%	100%/80%	100%/50%	100%	100%	100%
Extra cleaning	Not covered	Not covered	Not covered	Not covered	Not covered	For those who are pregnant or living with diabetes		
Basic services	No waiting period	No waiting period	Six-month waiting period	No waiting period	Six-month waiting period	Six-month waiting period		
Fillings	50%/50%	50%/50%	50%/25%	80%/60%	80%/40%	Not covered	80%	80%
Brush biopsy	Not covered	Not covered	Not covered	Not covered	Not covered	No covered	80%	80%
Complex and major services	No waiting period	No waiting period	12-month waiting period	No waiting period	12-month waiting period	12-month waiting period		
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50%/50%	50%/50%	30%/15%	50%/50%	50%/25%	Not covered	50%	50%
Prosthetics (crowns, dentures, bridges)	50%/50%	50%/50%	30%/15%	50%/50%	50%/25%	Not covered	Not covered	50%
Medically necessary orthodontia	50%/50%	50%/50%	Not covered	50%/50%	Not covered	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered	50%/50% Lifetime max $1,000	Not covered	Not covered	Not covered	Not covered
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person)	$100 (does not apply to D&P)	$100 (does not apply to D&P)	$50 (all services)	$25 (does not apply to D&P)	$50 (all services)	None	$50 (all services)	$50 (all services)
Yearly limit (per person)	None	None	$750	None	$1,000	$500	$1,000	$1,250
Yearly out-of-pocket limit	$350*/None	$350*/None	None	$350*/None	None	None	None	None
International Emergency Dental Program	Included	Included		Included		Included		
Optional Blue View Vision℠ coverage	Not available	Not available		Not available		Available		

* Per child, up to two children.

This is only a brief description of some plan benefits. Please refer to the *Certificate of Coverage* for more complete details including benefits, limitations and exclusions.

Individual dental and vision premiums for Nevada

Anthem BlueCross BlueShield

For policies with start dates beginning January 2015

We know that you have choices when it comes to health care coverage. Anthem Blue Cross and Blue Shield (Anthem) gives you access to complete dental coverage and one of the largest dental networks in the state. But cost is important to you, too.

Because insurance can be a big part of your budget, we make every effort to keep our costs low — so you pay less for coverage. The price you pay for your dental premium depends on several things, including how much dental care costs and where you live.

Anthem Dental Plans

With our Anthem Dental Pediatric, Anthem Dental Family and Anthem Dental Family Enhanced plans, you will not be charged premiums for more than three children, even if there are more children covered by the plan. For the Anthem Dental Family and Anthem Dental Family Enhanced plans, each dependent child ages 21-26 is rated, and then up to the three eldest children ages 0-20.

Rate area 1: Nye and Clark Counties

Rate area 2: Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Pershing, Storey, Washoe and White Pine Counties.

Anthem Dental Pediatric

	Area	
	1	2
1 Child	$26.27	$35.20
2 Children	$52.54	$70.40
3 or more children	$78.81	$105.60

Anthem Dental Family

	Area	
	1	2
1 Adult + 1 child	$54.15	$74.14
1 Adult + 2 children	$79.88	$108.58
1 Adult + 3 or more children	$105.61	$143.02
2 Adults + 1 child	$82.57	$113.84
2 Adults + 2 children	$108.30	$148.28
2 Adults + 3 or more children[1]	$134.03	$182.72

Anthem Dental Family Enhanced

	Area 1	Area 2
1 Adult + 1 child	$76.99	$102.84
1 Adult + 2 children	$112.29	$148.97
1 Adult + 3 or more children	$147.59	$195.10
2 Adults + 1 child	$118.68	$159.55
2 Adults + 2 children	$153.98	$205.68
2 Adults + 3 or more children[1]	$189.28	$251.81

Dental Prime

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Plan A		Plan B		Plan C	
	Monthly	*Annual*	*Monthly*	*Annual*	*Monthly*	*Annual*
ZIP codes starting with 889-891						
Individual	$22.70	$258.80	$36.55	$416.65	$45.80	$522.10
Individual + 1	$44.15	$503.30	$71.10	$810.55	$89.05	$1,015.15
Family	$70.60	$804.85	$113.75	$1,296.75	$142.50	$1,624.50
ZIP codes starting with 893-895, 897 and 898						
Individual	$30.00	$342.00	$48.35	$551.20	$60.55	$690.25
Individual + 1	$58.35	$665.20	$94.00	$1,071.60	$117.75	$1,342.35
Family	$93.40	$1,064.75	$150.40	$1,714.55	$188.45	$2,148.35

Blue View Vision℠

This optional vision rider is available only when purchased with Dental Prime

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Monthly	Annual
Individual	$8.65	$98.61
Individual + 1	$15.14	$172.57
Family	$24.23	$276.22

Anthem BlueCross BlueShield

1 For other combinations please talk to your broker or Sales representative.

Note: The children rates in the charts above are defined as dependent children ages 0 - 20.

Rates apply to members under age 65 and are subject to change.

As of January 1, 2014, the Affordable Care Act (ACA) or health care reform law, requires health insurers to pay an annual fee to fund premium subsidies and Medicaid expansion. This fee applies to fully insured dental and vision plans. The monthly premiums listed above include the ACA insurer fee.

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