

Summary of Benefits for BlueAdvantage HMO Plan

This is a general benefit summary for this health plan. A complete listing and description of benefits, limitations, and exclusions are found in the Certificate. Copayment options reflect the amount the member will pay.

	In-Network (HMO Providers)
<p>Out-of-Pocket Annual Maximum All copayment amounts contribute to the out-of-pocket annual maximum except copayment amounts related to prescription drugs.</p> <p>Some covered services have a maximum number of days, visits, dollar, or per occurrence amounts. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.</p>	<p>Individual: \$6,000</p> <p>Family: \$12,000</p>
<p>Lifetime Maximum Benefit</p>	<p>Unlimited for most covered services.</p> <p>Infertility services have a lifetime maximum benefit of \$2,000 per member.</p>
<p>Other information</p>	<p>Physicians are called a primary care physician (PCP) and the group of physicians is called a primary medical group (PMG). PCPs and PMGs are internal medicine physicians, family physicians or general practitioners for adults, pediatricians, family physicians, or general practitioners for children. At the time of enrollment, each member must select a PCP or PMG. Family members are not required to choose the same PCP or PMG; family members may select a PCP or PMG individually. In addition specialists are also covered, a specialist is usually a physician devoted to a specific disease, condition or body part. You may self-refer to specialists within the HMO Nevada network of covered providers.</p> <p>Bariatric surgery services has a per occurrence maximum benefit of \$5,000 per member.</p>

Services	In Network (Out-of-network care is not covered except as noted)	Additional Information
<p>1. Physician Visits</p> <p>a) Physician office visits and physician consultations</p> <p>b) Services related to physician office visit including but not limited to, allergy testing, allergy injections, or office surgeries</p> <p>c) Inpatient physician visits</p> <p>d) Urgent care physician visits</p>	<p>\$30 copayment per visit for PCP/PMG provider care and \$60 copayment per visit for specialists, plus \$30 copayment per visit for PCP/PMG provider care and plus \$60 copayment per visit for specialist provider care for any laboratory, pathology or x-ray services performed in conjunction with the physicians visit.</p> <p>\$30 copayment per visit for PCP/PMG provider care and \$60 copayment for specialist provider care in addition to office visit copayment</p> <p>Included in the inpatient hospital copayment</p> <p>\$60 copayment per visit, plus \$60 copayment per visit for laboratory, pathology or x-ray services performed in conjunction with the urgent care visit in addition to office visit copayment</p>	<p>For laboratory, pathology and x-ray services performed in conjunction with a physician's office visit. See line 3 for payment information.</p> <p>Physician visits include diabetic management and limited family planning services (see certificate for covered services).</p> <p>Urgent care may be received from your PCP/PMG or from an urgent care center.</p>
<p>2. Preventive Care</p> <p>Services include those that meet the requirements of federal and state law including screenings, immunizations and office visits.</p>	<p>No copayment (100% covered)</p>	

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Services	In Network (Out-of-network care is not covered except as noted)	Additional Information
<p>3. Diagnostic Services, Laboratory, Pathology, and X-ray</p> <p>a) Laboratory, Pathology, and X-ray</p> <p>b) MRI/MRA, PET, CT scans, nuclear medicine and other high tech services</p>	<p>\$30 copayment per visit for PCP/PMG provider care and \$60 copayment per visit for specialist provider care for any laboratory, pathology or x-ray services performed in conjunction with the physicians visit</p> <p>\$100 copayment per procedure for MRI, MRA and CT scans and \$750 copayment for PET scans</p>	<p>Services billed by a hospital are included in the hospital inpatient/outpatient benefits. Diagnostic services must be ordered by a covered HMO Nevada provider to be a covered service.</p>
<p>4. Maternity Care</p> <p>a) Prenatal care</p> <p>b) Delivery & inpatient baby care</p>	<p>\$30 copayment per visit for PCP/PMG provider care and \$60 copayment per visit for specialists, plus \$30 copayment per visit for PCP/PMG provider care and plus \$60 copayment per visit for specialist provider care for any laboratory, pathology or x-ray services performed in conjunction with the physicians visit.</p> <p>\$500 copayment per day; Maximum per admission copayment of \$2,000</p>	<p>For laboratory, pathology and x-ray services performed in conjunction with a physician's office visit see line 3 for payment information. Limited to one routine ultrasound per pregnancy.</p>
<p>5. Outpatient Therapies: Physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and spinal manipulations</p> <p>a) Outpatient physical therapy, occupational therapy, speech therapy and cardiac rehabilitation</p> <p>b) Outpatient spinal manipulations</p>	<p>\$60 copayment per visit</p> <p>\$30 copayment per visit</p>	<p>Limited to an aggregate of 30 visits total for physical, occupational and speech therapy per member per year. Benefits are paid up to 36 visits for cardiac rehabilitation. The program must start within three months of the major cardiac event and be completed within six months of the major cardiac event.</p> <p>Limited to a maximum of 12 visits per member per year</p>

Services	In Network (Out-of-network care is not covered except as noted)	Additional Information
6. Hospital Care/Other Facility Services a) Inpatient b) Inpatient - acute rehabilitation therapy c) Outpatient Surgery d) Outpatient Services e) Urgent Care Facility	\$500 copayment per day; Maximum per admission copayment of \$2,000 \$500 copayment per day; Maximum per admission copayment of \$2,000 \$400 copayment per surgery \$30 copayment per visit for PCP/PMG provider care and \$60 copayment per visit for specialists \$60 copayment per visit plus \$60 copayment per visit for laboratory, pathology or x-ray services performed in conjunction with the urgent care visit	The inpatient copayment includes surgical procedures. Limited to 30 inpatient days per member per year.
7. Emergency Care	\$300 copayment per emergency room visit	Care is covered in-network and out-of-network. Copayment is waived if admitted, however the inpatient copayment will apply.
8. Ambulance Services a) Ground Services b) Air Services	\$300 copayment per trip \$300 copayment per trip	Care is covered in-network and out-of-network. Copayment is waived if admitted, however the inpatient copayment will apply. Benefits are paid for medically necessary ground or air ambulance transportation.
9. Mental Health and Substance Abuse Care a) Inpatient b) Outpatient - Office visit/professional - Facility	\$500 copayment per day; Maximum per admission copayment of \$2,000 \$30 copayment per visit No copayment (100% covered)	
10. Medical Supplies and Equipment	No copayment (100% covered)	Includes diabetic supplies and equipment, medical supplies, durable medical equipment, oxygen and equipment, orthopedic appliances, prosthetic devices and other appliances.
11. Home Health Care	\$60 copayment per visit	

Services	In Network (Out-of-network care is not covered except as noted)	Additional Information
12. Chemotherapy, Hemodialysis, and Radiation Therapy a) Inpatient b) Outpatient	\$500 copayment per day; Maximum per admission copayment of \$2,000 \$30 copayment per visit	
13. Skilled Nursing Facility	\$500 copayment per day; Maximum per admission copayment of \$2,000	Copayment is waived if admitted directly to a skilled nursing facility from an inpatient acute facility. Limited to 100 inpatient days per member per year.
14. Hospice Care	No copayment (100% covered)	
15. Human Organ and Tissue Transplants a) Inpatient b) Outpatient	\$500 copayment per day; Maximum per admission copayment of \$2,000 \$30 copayment per visit for PCP/PMG provider care and \$60 copayment per visit for specialists, plus \$30 copayment per visit for PCP/PMG provider care and plus \$60 copayment per visit for specialist provider care for any laboratory, pathology or x-ray services performed in conjunction with the physicians visit.	See the certificate for details on covered transplants. Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches for bone marrow and stem cells are limited to a maximum benefit of \$30,000.
16. Temporomandibular Joint Syndrome a) Inpatient Surgery b) Outpatient Surgery c) Outpatient Physician Visits	\$500 copayment per day; Maximum per admission copayment of \$2,000 \$500 copayment per surgery \$30 copayment per visit for PCP/PMG provider care and \$60 copayment per visit for specialists, plus \$30 copayment per visit for PCP/PMG provider care and plus \$60 copayment per visit for specialist provider care for any laboratory, pathology or x-ray services performed in conjunction with the physicians visit.	
17. Enteral Formula and Special Foods	No copayment (100% covered)	Special food products that are prescribed or ordered by a physician as medically necessary are allowed.

<p>18. Prescription Drugs</p> <p>a) Outpatient Retail Pharmacy Drugs and Specialty Pharmacy Drugs</p> <p>Specialty pharmacy drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. They are often unavailable at an outpatient retail pharmacy or mail order pharmacy since these drugs may require special handling such as temperature controlled packaging and overnight delivery. These specialty pharmacy drugs are available from the Pharmacy Benefits Manager (PBM).</p>	<p>Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 20% copayment, per prescription at a participating pharmacy or specialty pharmacy up to a 30-day supply.</p>
<p>b) Mail Order Pharmacy Drugs</p>	<p>Tier 1 \$15 copayment, tier 2 \$60 copayment, per prescription through the mail-order service up to a 90-day supply. Specialty pharmacy drugs are not available by mail order.</p>
<p>The following applies to a) and b) above: For the tier 3 outpatient retail pharmacy drugs, the maximum member copayment per prescription is \$200 per 30-day supply.</p>	
<p>Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your generic copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at (877) 811-3106.</p>	
<p>Coverage is limited to prescription drugs that are listed on Anthem's Generic Premium Formulary which contains a limited number of prescription drugs. Generally the Generic Premium Formulary will include most generic drugs, but typically no more than one or two brand name prescription drugs in a therapeutic class. Certain therapeutic classes may have no brand name prescription drugs on the Generic Premium Formulary because of the number of generic drugs available in those therapeutic classes.</p>	

HMO Nevada
Benefit Summary Disclosure Information
BlueAdvantage HMO
700 Broadway, Denver, CO 80273
877-811-3106

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

Coverage for treatment as part of a clinical trial:

Includes coverage for medical treatment provided in a Phase I, Phase II, Phase III or Phase IV clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome conducted in the state of Nevada.

Coverage for medical treatment is limited to:

- Any drug or device approved for sale by the Food and Drug Administration.
- The cost of any reasonably necessary health care services required from the medical treatment or complications thereof arising out of the medical treatment provided in the clinical trial.
- The initial consultation to determine whether the person is eligible to participate in a clinical trial.

Health care services required for the clinically appropriate monitoring of the person during the clinical trial.

Coverage for the management and treatment of diabetes

Includes coverage for medication, equipment, supplies, and appliances that are medically necessary for the treatment of diabetes type I, type II, and gestational diabetes.

Coverage for self-management of diabetes, including:

- The training and education provided to a person covered under the contract after initial diagnosis of diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the program of self-management of diabetes.
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that HMO Nevada, subject to a member's right to appeal, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member's family or the provider.

- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

Emergency

Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the insured, or
- Serious jeopardy to the health of an unborn child, or
- Serious impairment to bodily functions, or
- Serious and permanent dysfunction of any bodily organ or part.

Maximum Benefits

Some services or supplies may have an annual or lifetime maximum benefit, be sure to review your summary of benefits for further details on what services may have a maximum benefit.

Away from Home Care Access

When the member is temporarily away from the HMO Nevada service area (90 days or less) and needs urgent or after-hours medical care, the member must follow the steps outlined below:

- For emergency care, call 911 or go directly to the nearest hospital. Notify HMO Nevada within 24 hours of treatment or admission or as soon as reasonably possible.
- For non-emergency care, call the member's PCP/PMG or HMO Nevada for preauthorization. The preauthorization phone number is on the back of the member's health plan identification card.
- To find the names and addresses of nearby doctors and hospitals, visit the BlueCard® Doctor and Hospital Finder at bcbs.com, or call BlueCard Access toll free at 1-800-810-BLUE.
- When members arrive at the participating doctor's office or hospital, simply present the health plan identification card.

After receiving care, members should not have to complete any claim forms or pay up front for medical services, except for the out-of-pocket expenses (non-covered services and copayments) that members would usually pay.

If members will be in a different service area for at least 90 consecutive days, the Guest Membership benefits help to ensure that they have ongoing access to their HMO Nevada health care benefits. To set-up membership, follow these steps:

If members will be in a different service area for at least 90 consecutive days, the Guest Membership benefits help to ensure that they have ongoing access to their HMO Nevada health care benefits. To set-up membership, follow these steps:

- Call Guest Membership toll free at 1-800-827-5422 for eligibility and specific location information. Guest Membership is not available in all areas.
- If a participating HMO (Host HMO) is in the member's destination area, Guest Membership will send an application to complete, sign and return in an enclosed self-addressed envelope. Guest Membership will forward the completed application to the Host HMO. Please allow 20-30 calendar days for processing of the application.
- The Host HMO will send the member a health plan identification card, the name of their Primary Care Physician (in some cases, members may be asked to choose a Primary Care Physician), and information on how to use their Guest Membership.
- The Host HMO does not cover dental, vision, chiropractic care and substance abuse rehabilitation.
- Use the HMO Nevada health plan identification card to access prescription benefits in the Host HMO area.

Members won't have to complete a claim form or pay up front for their health care services, except for the out-of-pocket expenses (non-covered services and copayments) they would normally pay.

Benefits under the Host HMO may differ from those members would pay to HMO Nevada. Payment information will be included in the member's Guest Membership kit.

Limitations and Exclusions

This plan does not cover some services. The plan includes limitations and exclusions to protect against duplicate or unnecessary services that could unfairly offset the cost of health care coverage for the entire plan. Following are examples of the plan's limitations and exclusions:

- Benefits provided under any local, state, or federal laws, including Workers' Compensation and Medicare
- Cosmetic surgery
- Services by a family member
- Weight-reduction services and medications
- Complications from non-covered services
- Our payment allowance will be reduced or denied from what would have been paid if pre-certification is not obtained prior to receiving inpatient hospital services and outpatient surgeries.
- Most services, such as non-emergency hospital admissions or surgical procedures require prior authorization.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), clonics or iridology.
- Artificial conception
- Services received before the effective date of coverage.
- Biofeedback.
- Chelating agents except for providing treatment for heavy metal poisoning.
- Services or supplies provided as part of clinical research, except where required by law or allowed by HMO Nevada.
- Convalescent care
- Convenience, luxury, deluxe services or equipment. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).
- Court ordered services unless those services are otherwise covered under the certificate.
- Custodial care.
- Dental services except for accident related dental services, dental anesthesia for children, temporomandibular joint therapy or surgery.
- Inpatient care received after the date HMO Nevada, using managed care guidelines, determines discharge is appropriate.
- Hospital care if the member leaves a hospital against the medical advice of the physician, charges which are a direct result of the member's knowing and voluntary non-compliance of medically necessary care with prescribed medical treatment are not eligible for coverage.
- Domiciliary care such as care provided in residential, non-treatment institution, halfway house or school.
- Services and supplies already covered by other valid coverage.
- Experimental/Investigative procedures.
- Genetic counseling.

- Government operated facility such as a military medical facility or veteran's administration facility unless authorized by HMO Nevada.
- Hair loss, drugs, wigs, hairpieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a physician prescription, and a medical reason for the hair loss.
- Hearing aids or routine hearing tests.
- Hypnosis, whether for medical or anesthesia purposes.
- This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony which they are convicted of.
- Therapies for learning deficiencies and/or behavioral problems.
- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to keep a scheduled appointment.
- Neuropsychiatric testing.
- Non-covered providers who include but are not limited to:
 - Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
 - School infirmary.
 - Halfway house.
 - Massage therapist.
 - Nursing home.
 - Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Non-medical expenses, including but not limited to:
 - Adoption expenses.
 - Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
 - Vocational training services and supplies.
 - Mailing and/or shipping and handling expenses.
 - Interest expenses and delinquent payment fees.
 - Modifications to home, vehicle, or workplace regardless of medical condition or disability.
 - Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
 - Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
 - Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
 - Voice synthesizers or other communication devices, except as specifically allowed by HMO Nevada's medical policy.
- Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital imperfection or acquired characteristic.
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use. These include but are not limited to, home pregnancy tests and home HIV tests.

- Benefits are not provided for care received after coverage is terminated.
- Private duty nursing services.
- Private rooms are not covered.
- Charges for services and supplies when the member has received a professional or courtesy discount from a provider or where the member's portion of the payment is waived due to professional courtesy or discount.
- Peripheral bone density testing. This coverage does not cover the following except as described by medical policy screening or as provided in the certificate, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.
- Charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.
- Services or supplies necessitated by injuries which a member intentionally self-inflicted, except where the law prohibits such an exclusion.
- Services or supplies related to sex change operations, reversals of such procedures, complications of such procedures, or services, supplies or medications related to a sex change operation.
- Treatment of sexual dysfunction or impotence including all services, supplies or prescription drugs used for the treatment.
- Smoking cessation programs, products, drugs or medications, hypnosis, supplies or devices to quit smoking.
- Services and supplies which may be reimbursed by a third party.
- Travel or lodging expenses for the member, member's family or the physician except as travel or lodging expenses related to human organ and tissue transplants.
- Routine eye examinations, routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which requires the use of contact lenses), or prescriptions for such services and supplies. Surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.
- Whole blood, blood plasma and blood derivatives received from community sources or replaced through donor credit.
- Treatment of infertility.
- Bariatric surgery services over the maximum of \$5,000 per member per occurrence.

Rate determinations

Rates are calculated based on allowable case characteristics of member age, gender, geographic location, dependent enrollment, group size, industry, and health status.

Provider Directories

Copies of provider directories for all products offered by HMO Nevada may be obtained by calling the customer service department or accessing the information on our Internet site at www.Anthem.com.

Provider Network

Under HMO Nevada, if care is not provided by the member's Primary Care Physician or other network provider and care is received by a doctor who does not participate in the HMO Nevada provider network, the member may have to pay for those services.

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