

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

CORE INNOVATIVE SOLUTIONS

**Guided Access HMO \$20 \$6500/40%/\$8500L 15/45/75/30%
Essential Tiered Rx**

01-01-2026



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

HMO Nevada

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Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network.

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your out-of-pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent, you will be responsible for all charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your out-of-pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will not be covered. This means you will be responsible for all Out-of-Network charges for those services. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your out-of-pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic

services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your out-of-pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider

How Cost Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any out-of-pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Grievance and External Review Procedures" section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and federal agencies if you believe a Provider has violated the No Surprises Act.

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of your ID card:

- Cost sharing information for covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

In addition, Anthem will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

Notice Regarding Retiree-Only Plans

If this Plan is issued as part of a retiree-only plan, as defined by ERISA §732(a) and IRC §9831(a)(2), the provisions of the Consolidated Appropriations Act of 2021 will not apply, including the provisions regarding the No Surprises Act. In a retiree-only plan, Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount. Please contact your Group if you are unsure whether your plan is a retiree-only plan.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need a referral from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out-of-pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment, Coinsurance and

out-of-pocket expenses applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Group.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a

written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Notices Required by State Law

Division of Insurance Inquiries

For inquiries about health care coverage in Nevada, please call the Division of Insurance within the Department of Business and Industry between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday and ask for the Division of Insurance. The toll free number is (888) 872-3234 and the local numbers are (775) 687-0700 in Carson City and (702) 486-4009 in Las Vegas.

Although the numbers above are designed to assist members with inquiries and complaints about health care coverage in Nevada, the Division of Insurance is not equipped to resolve customer service related inquiries. Please continue to refer these types of inquiries to HMO Nevada's Member Services department at the number on the back of your ID card.

Introduction

Welcome to HMO Nevada!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

Your Group has agreed to be subject to the terms and conditions of HMO Nevada's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield or any of our subsidiaries, affiliates, subcontractors, or designees. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

HMO Nevada is committed to communicating with our Members about their health Plan, no matter what their language is. HMO Nevada employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



Mike Murphy
President and General Manager
HMO Nevada

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, Urgent Care or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service.

Benefits are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an approved Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for additional details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Service Area Where Plan is Offered	Carson City Clark, Douglas, Lyon, Nye, Storey, and Washoe counties.
Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26.
	Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Deductible	In-Network
Per Member	\$6,500
Per Family – All other Members combined	\$13,000
When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.	
Copayments and Coinsurance are separate from and do not apply to the Deductible.	

Coinsurance	In-Network
Plan Pays	60%
Member Pays	40%
Reminder: Except for Surprise Billing Claims, your Coinsurance will be based on the Maximum Allowed Amount. If you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount.	
Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.	

Out-of-Pocket Limit	In-Network
Per Member	\$8,500
Per Family – All other Members combined	\$17,000
The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or charges for non-Covered Services.	
No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of-Pocket Limit is satisfied, you will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period.	

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Acupuncture	See "Therapy Services."	Not covered
Allergy Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services". For services in an urgent care center look up "Urgent Care Services (Office & Home Visits)."	Not covered
Ambulance Services (Ground, Air, and Water) Emergency Services	40% Coinsurance after Deductible	
For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.		

Benefits	In-Network	Out-of-Network
Ambulance Services (Ground, Air, and Water) Non-Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Getting Approval for Benefits" for details.	40% Coinsurance after Deductible	
Autism Services <ul style="list-style-type: none"> Applied Behavior Analysis - Professional Visits Applied Behavior Analysis – Outpatient Facility Habilitative and Rehabilitative Services	\$20 Copayment per visit 40% Coinsurance after Deductible Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services". For services during an Inpatient stay, look up "Inpatient Services".	Not covered Not covered Not covered
Cardiac Rehabilitation	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Cellular and Gene Therapy Services <ul style="list-style-type: none"> Precertification required 	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."	Not covered
Chemotherapy	See "Therapy Services."	Not covered
Chiropractic Services	See "Therapy Services."	Not covered
Clinical Trials	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."	Not covered

Benefits	In-Network	Out-of-Network
Dental Services (All Members / All Ages) (Limited to services for accidental injury, or to prepare the mouth for certain medical treatments)	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."	Not covered
Diabetic Services Screenings for gestational diabetes are covered under "Preventive Care."		
<ul style="list-style-type: none"> Diabetic Equipment and Supplies 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Diabetic Education (Including Self-Management Programs) 	Benefits for diabetic education are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services".	Not covered
Diagnostic Services		
<ul style="list-style-type: none"> Reference Labs 	40% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> All Other Diagnostic Services 	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."	Not covered
Dialysis	See "Therapy Services."	Not covered
Durable Medical Equipment (DME), Medical Devices, and Supplies		
<ul style="list-style-type: none"> Durable Medical Equipment(including Enteral Formulas and Special Foods) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Orthotics 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Prosthetics 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Prosthetic Limbs 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Wigs 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Medical and Surgical Supplies 	40% Coinsurance after Deductible	Not covered
The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
Wigs Needed After Cancer Treatment Benefit Maximum	One wig up to a maximum benefit of \$500 per Member	Not covered
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that		

Benefits	In-Network	Out-of-Network
exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.		
Emergency Room Services Emergency Room <ul style="list-style-type: none"> Emergency Room Facility Charge 40% Coinsurance after Deductible Emergency Room Doctor Charge (e.g. ER Physician, radiologist, anesthesiologist, surgeon) 40% Coinsurance after Deductible Emergency Room Doctor Charge (Mental Health / Substance Use Disorder) 40% Coinsurance after Deductible Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) 40% Coinsurance after Deductible Advanced Diagnostic Imaging (including MRIs, CAT scans) 40% Coinsurance after Deductible <p>For Covered Emergency Services from an Out-of-Network Provider at a Facility in Nevada, you do not need to pay any more than would have paid for services from an In-Network Provider, and you are not responsible for the charges over the Plan's Maximum Allowed Amount. For other Covered Emergency Services from an Out-of-Network Provider, that Provider may also bill you for any charges over the Plan's Maximum Allowed Amount.</p> <p>As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, for Emergency Services Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.</p>		
Habilitative Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services". See "Therapy Services" for details on Benefit Maximums.	Not covered

Benefits	In-Network	Out-of-Network
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency (Including intermittent skilled nursing services)	40% Coinsurance after Deductible	Not covered
• Home Dialysis	40% Coinsurance after Deductible	Not covered
• Home Infusion Therapy / Chemotherapy	40% Coinsurance after Deductible	Not covered
• Specialty Prescription Drugs for Infusion / Injection – Other than Chemotherapy	40% Coinsurance after Deductible	Not covered
• Other Home Health Care Services / Supplies	40% Coinsurance after Deductible	Not covered
• Private Duty Nursing (Including continuous complex skilled nursing services)	40% Coinsurance after Deductible	Not covered
Home Health Care and Private Duty Nursing Benefit Maximum combined	<p>100 visits per Benefit Period.</p> <p>The limit includes Private Duty Nursing and Therapy Services* (e.g., physical, speech, and occupational rehabilitation) given as part of the Home Care benefit.</p> <p>The limit does not apply to Home Infusion Therapy or Home Dialysis.</p> <p>*If Therapy Services are provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits and the Home Health Care limit will not apply.</p>	Not covered
Home Infusion Therapy		
	See "Home Care."	Not covered

Benefits	In-Network	Out-of-Network
Hospice Care		
• Home Hospice Care	40% Coinsurance after Deductible	Not covered
• Bereavement	40% Coinsurance after Deductible	Not covered
• Inpatient Hospice	40% Coinsurance after Deductible	Not covered
• Outpatient Hospice	40% Coinsurance after Deductible	Not covered
• Respite Care	40% Coinsurance after Deductible	Not covered
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services		
• Precertification required	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."	Not covered
• Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant	Not covered
• Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Donor Health Service Limit 	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, If the live donor is not a Member, complications from the donor procedure are covered up to six weeks from the date of procurement.	Not covered
Infertility Services	See "Maternity and Reproductive Health Services."	Not covered
Inpatient Services		
Facility Room & Board Charge:		
<ul style="list-style-type: none"> Hospital / Acute Care Facility 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Skilled Nursing Facility 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Rehabilitation 	40% Coinsurance after Deductible	Not covered
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Inpatient Rehabilitation Program) Benefit Maximum (Combined)	150 days per Benefit Period	Not covered
<ul style="list-style-type: none"> Mental Health / Substance Use Disorder Facility 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Residential Treatment Center 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Ancillary Services 	40% Coinsurance after Deductible	Not covered
Doctor Services when billed separately from the Facility for:		
<ul style="list-style-type: none"> General Medical Care / Evaluation and Management (E&M) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Surgery 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Maternity 	40% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Mental Health / Substance Use Disorder Services 	40% Coinsurance after Deductible	Not covered
Maternity and Reproductive Health Services		
<ul style="list-style-type: none"> Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Inpatient Services (Delivery) 	See "Inpatient Services."	Not covered
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder Services		
	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services". For services during an Inpatient stay, look up "Inpatient Services".	Not covered
Occupational Therapy		
	See "Therapy Services."	Not covered
Office and Home* Visits		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
<ul style="list-style-type: none"> Primary Care Physician / Provider (PCP) 	In-Person Visits: \$20 Copayment per visit Virtual Visits: \$20 Copayment per visit	Not covered
<ul style="list-style-type: none"> Additional Telehealth/Telemedicine Services from a Primary Care Provider (PCP) (as required by law) 	\$20 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Mental Health and Substance Use Disorder Provider – Including Psychotherapy and Habilitative / Rehabilitative Therapy Services 	In-Person Visits: \$20 Copayment per visit Virtual Visits: \$20 Copayment per visit	Not covered
<ul style="list-style-type: none"> Specialty Care Physician / Provider (SCP) 	In-Person Visits: \$60 Copayment per visit Virtual Visits: \$60 Copayment per visit	Not covered
<ul style="list-style-type: none"> Additional Telehealth/Telemedicine Services from a Specialty Care Provider (SCP) (as required by law) 	\$60 Copayment per visit	Not covered
<ul style="list-style-type: none"> Retail Health Clinic Visit 	\$20 Copayment per visit	Not covered
<ul style="list-style-type: none"> Family Planning, Diabetic Education, and Nutritional Counseling (Medical) 	\$20 Copayment per visit	Not covered
<ul style="list-style-type: none"> Nutritional Counseling (Mental Health and Substance Use Disorder) 	\$20 Copayment per visit	Not covered
<ul style="list-style-type: none"> Allergy Testing 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Shots / Injections (other than allergy serum) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Allergy Shots / Injections (including allergy serum) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Diagnostic Lab (other than reference labs) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Diagnostic X-ray 	\$20 Copayment per day	Not covered
<ul style="list-style-type: none"> Other Diagnostic Tests (including hearing and EKG) 	\$20 Copayment per visit	Not covered
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) 	\$400 Copayment per service	Not covered
<ul style="list-style-type: none"> Office Surgery (including anesthesia) 	40% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Therapy Services: <ul style="list-style-type: none"> Chiropractic / Osteopathic / Manipulative Therapy 	\$20 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
– Acupuncture	\$20 Copayment per visit	Not covered
– Physical Therapy*	\$20 Copayment per visit	Not covered
– Speech Therapy*	\$20 Copayment per visit	Not covered
– Occupational Therapy*	\$20 Copayment per visit	Not covered
– Dialysis	40% Coinsurance after Deductible	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	40% Coinsurance after Deductible	Not covered
– Cardiac Rehabilitation	40% Coinsurance after Deductible	Not covered
– Pulmonary Therapy	40% Coinsurance after Deductible	Not covered
– Cognitive Rehabilitation Therapy*	\$20 Copayment per visit	Not covered
See “Therapy Services” for details on Benefit Maximums.		
*If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.		
• Prescription Drugs Administered in the Office (other than allergy serum)	40% Coinsurance after Deductible	Not covered
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies.”	Not covered
Outpatient Facility Services If your PCP or SCP office visit is billed from an Outpatient Facility, the services will be payable the same as in an office setting. Please refer to the “Office Visits” section in this Schedule for details on the cost shares that will apply.		
• Facility Surgery Charge	40% Coinsurance after Deductible	Not covered
• Facility Surgery Lab	40% Coinsurance after Deductible	Not covered
• Facility Surgery X-ray	40% Coinsurance after Deductible	Not covered
• Ancillary Services	40% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
• Doctor Surgery Charges	40% Coinsurance after Deductible	Not covered
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant), Nutritional Counseling, and Diabetes Education	40% Coinsurance after Deductible	Not covered
• Other Facility Charges (for procedure rooms)	40% Coinsurance after Deductible	Not covered
• Mental Health / Substance Use Disorder Services		
Outpatient Facility Charges	40% Coinsurance after Deductible	Not covered
Professional Charges – Partial Hospitalization Program / Intensive Outpatient Program and Psychotherapy	40% Coinsurance after Deductible	Not covered
Professional Charges – Nutritional Counseling and Habilitative / Rehabilitative Therapies	40% Coinsurance after Deductible	Not covered
• Shots / Injections (other than allergy serum)	40% Coinsurance after Deductible	Not covered
• Allergy Shots / Injections (including allergy serum)	40% Coinsurance after Deductible	Not covered
• Diagnostic Lab	40% Coinsurance after Deductible	Not covered
• Diagnostic X-ray	40% Coinsurance after Deductible	Not covered
• Other Diagnostic Tests: EKG, EEG, etc.	40% Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	40% Coinsurance after Deductible	Not covered
• Therapy:		
– Chiropractic / Osteopathic / Manipulative Therapy	40% Coinsurance after Deductible	Not covered
– Acupuncture	40% Coinsurance after Deductible	Not covered
– Physical Therapy*	40% Coinsurance after Deductible	Not covered
– Occupational Therapy*	40% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
– Speech Therapy*	40% Coinsurance after Deductible	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	40% Coinsurance after Deductible	Not covered
– Dialysis	40% Coinsurance after Deductible	Not covered
– Cardiac Rehabilitation	40% Coinsurance after Deductible	Not covered
– Pulmonary Therapy	40% Coinsurance after Deductible	Not covered
Cognitive Rehabilitation Therapy*	40% Coinsurance after Deductible	Not covered
See “Therapy Services” for details on Benefit Maximums.		
*If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	40% Coinsurance after Deductible	Not covered
Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers If your PCP or SCP office visit is billed from a Site of Service Ambulatory Surgical Facility, the services will be payable the same as in an office setting. Please refer to the “Office and Home Visits” section in this Schedule for details on the cost shares that will apply.		
• Ambulatory Surgery Center - Facility Surgery	\$400 Copayment per visit	Not covered
• Ambulatory Surgery Center – Surgery Lab	\$400 Copayment per visit	Not covered
• Ambulatory Surgery Center – Surgery X-ray	\$400 Copayment per visit	Not covered
• Ambulatory Surgery Center – Ancillary Services	\$400 Copayment per visit	Not covered
• Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgery, Surgical Assistant)	No Copayment, Deductible, or Coinsurance	Not covered
• Radiology Center - Diagnostic X-ray	\$20 Copayment per visit	Not covered
• Radiology Center - Advanced Diagnostic Imaging (including MRIs, CAT scans)	\$400 Copayment per service	Not covered
Physical Therapy	See “Therapy Services.”	Not covered

Benefits	In-Network	Out-of-Network
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered
Preventive Care for Chronic Conditions (per IRS guidelines)		
<ul style="list-style-type: none"> Prescription Drugs 	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.	Not covered
<ul style="list-style-type: none"> Medical items, equipment and screenings 	No Copayment, Deductible, or Coinsurance	Not covered
Please see the "What's Covered" section for additional detail on IRS guidelines.		
Prosthetics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies."	Not covered
Pulmonary Therapy	See "Therapy Services."	Not covered
Radiation Therapy	See "Therapy Services."	Not covered
Rehabilitation Services	<p>Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."</p> <p>See "Inpatient Services" and "Therapy Services" for details on Benefit Maximums.</p>	Not covered

Benefits	In-Network	Out-of-Network
Respiratory Therapy	See "Therapy Services."	Not covered
Skilled Nursing Facility	See "Inpatient Services."	Not covered
Speech Therapy	See "Therapy Services."	Not covered
Surgery	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." Benefits are covered at no less than 50% of the Plan's Maximum Allowed Amount.	Not covered

Benefits	In-Network	Out-of-Network
Therapy Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	Not covered
Benefit Maximum(s):	Benefit Maximum(s) are for office and outpatient visits combined and for rehabilitative and habilitative services combined	Not covered
• Physical & Occupational Therapy (Rehabilitative & Habilitative)	40 visits per Benefit Period	Not covered
• Speech Therapy (Rehabilitative & Habilitative)	20 visits per Benefit Period	Not covered
• Manipulation Therapy	20 visits per Benefit Period	Not covered
	Limit does not apply to osteopathic therapy	
• Acupuncture	20 visits per Benefit Period	Not covered
• Cardiac Rehabilitation	36 visits per Benefit Period	Not covered
• Pulmonary Rehabilitation	Unlimited	Not covered
• Speech therapy and speech-language pathology for treatment of stuttering until the Member reaches 26 years of age.	Unlimited	Not covered
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: The limits for physical, occupational, and speech therapy will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit (based on the primary diagnosis on the claim form).		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		

Benefits	In-Network	Out-of-Network
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	Not covered
Urgent Care Services (Office & Home* Visits)		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Visit Charge	\$60 Copayment per visit	Not covered
• Allergy Testing	40% Coinsurance after Deductible	Not covered
• Shots / Injections (other than allergy serum)	40% Coinsurance after Deductible	Not covered
• Allergy Shots / Injections (including allergy serum)	40% Coinsurance after Deductible	Not covered
• Diagnostic Lab (other than reference labs)	40% Coinsurance after Deductible	Not covered
• Diagnostic X-ray	\$20 Copayment per day	Not covered
• Other Diagnostic Tests (including hearing and EKG)	\$20 Copayment per day	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	\$400 Copayment per visit	Not covered
• Office Surgery (including anesthesia)	40% Coinsurance after Deductible	Not covered
• Prescription Drugs Administered in the Office (other than allergy serum)	40% Coinsurance after Deductible	Not covered
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Virtual Visits (from Virtual Care-Only Providers)		
	Virtual Visits Conducted through our Mobile App and Website:	Other Virtual Visits:
• Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services)	No Copayment, Deductible, or Coinsurance	Not covered
• Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services)	No Copayment, Deductible, or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Virtual Visits from Virtual Care-Only Providers (Specialty Care Services) <p>If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.</p>	\$60 Copayment per visit	Not covered
<p>Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye)</p> <p>Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.</p>	<p>Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services in an ambulatory surgery center, look up "Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers." For services during an Inpatient stay, look up "Inpatient Services."</p>	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
<p>Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.</p> <p>Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.</p>		
Retail Pharmacy	30 days	
	<p>Note: A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.</p>	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy	30 days*	
	<p>*See additional information in the "Specialty Drug Copayments / Coinsurance" section below.</p>	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Note: Prescription Drugs that we are required to cover by applicable federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.		
Level 1 Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$15 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	\$45 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	\$75 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	30% Coinsurance to a maximum of \$500 per Prescription Drug	Not covered
Level 2 Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$25 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	\$55 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	\$85 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	30% Coinsurance to a maximum of \$600 per Prescription Drug	Not covered
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$37.50 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	\$112.50 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	\$225 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	30% Coinsurance to a maximum of \$500 per Prescription Drug	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
<p>Specialty Drug Copayments / Coinsurance:</p> <p>Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please refer to “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.</p> <p>Also see the “Drug Cost Share Assistance Programs” section for information about applicable cost share amounts applicable to Specialty Drugs that are eligible for cost share assistance. Please note that we may increase the cost shares listed above in order to take full advantage of cost share assistance that is available from drug manufacturers. This will lower plan costs but will not increase your cost because any additional cost share will be offset by the cost share assistance.</p> <p>If you do not use the Specialty Pharmacy, benefits will be covered at the Out-of-Network level.</p> <p>Orally administered cancer chemotherapy drugs are covered In-Network with a Member cost share no greater than \$100 per prescription in accordance with applicable state law.</p> <p>Prescription insulin drugs are covered In-Network with a Member cost share no greater than \$35 per prescription for a 30-day supply in accordance with applicable state law.</p> <p>Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.</p>		

How Your Plan Works

Introduction

Your Plan is an HMO plan. **To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves Emergency or Urgent Care.**

To find an In-Network Provider for this Plan, please see “How to Find a Provider in the Network,” later in this section.

In-Network Provider Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services.

If you receive Covered Services from an Out-of-Network Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians, gynecologists, and geriatricians. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care. If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

Selecting a Primary Care Physician

Your Plan requires you to select a Primary Care Physician from our network, or we will assign one. We will notify you of the PCP that we have assigned. You may then use that PCP or choose another PCP from our Provider Directory. Please see “How to Find a Provider in the Network” for more details.

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians, gynecologists, and geriatricians. Each member of a family may select a different Primary Care Physician; for example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, contact us or refer to our website, www.anthem.com.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you choose a PCP, make an appointment with your PCP. During this appointment, get to know your PCP and help your PCP get to know you. At your first appointment, talk to your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns you have.

It is important to note, if you have not established a relationship with your PCP, they may not be able to effectively treat you. To see a Doctor, call their office:

- Tell them you are an HMO Nevada Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If you need to see a Specialist, please contact your PCP to get a Referral. A Referral is not required to visit the following In-Network Providers:

- Ob/Gyn;
- Certified nurse midwife
- Optometrist or ophthalmologist;
- Autism Services Provider;
- Professional Providers for the treatment of Alcohol Dependency, Mental Health Conditions or Substance Dependency;
- Neonatal Providers;
- A Referral is not required for Emergency or Urgent Care services and Emergency Ambulance services.

Members can choose to self-refer to the above Providers as long as they are In-Network Providers.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room. If you are experiencing a mental health crisis, you may also call 988 for assistance.

Surprise Billing Claims

Surprise Billing Claims are described in the “Consolidated Appropriations Act of 2021 Notice” at the beginning of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

As soon as you enroll in this Plan, you should download our mobile app. You can find details on how to do this on our website, www.anthem.com.

Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, www.anthem.com.

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the network for this Plan. 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 www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan’s network.
- Search for a Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan’s network, based on specialty and geographic area. Member Services can help you determine the Provider’s name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases, you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

If you need details about a Provider’s license or training, or help choosing a Doctor who is right for you, call the Member Services 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.

Continuity of Care

If your In-Network Provider leaves our network for any reason other than termination for cause, retirement or death, or if coverage under this Plan ends because your Group’s Contract ends, or because your Group changes plans, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. “Active treatment” includes:

- An ongoing course of treatment for a life-threatening condition, including a chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time,
- An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy and post-operative visits),
- An ongoing course of treatment for pregnancy and through the postpartum period,

- A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery,
- An ongoing course of treatment for a health condition, including Prescription Drugs, for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes, or
- Continuing care benefits for Members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or Facility.

An “ongoing course of treatment” includes treatments for Mental Health and Substance Use Disorders.

In these cases, you may be able to continue seeing that Provider until treatment is complete, up to 120 days after the Provider has left Our network and for pregnant or postpartum Members, up to 90 days following delivery. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by us regarding a request for Continuity of Care is subject to the Grievance and External Review Procedures process.

Your Cost Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost shares you must pay. Please read the “Schedule of Benefits” for details on your cost shares. Also read the “Definitions” section for a better understanding of each type of cost share.

Benefit Maximum

Some Covered Services have a maximum number of days, visits or dollar amounts that we will allow during a Benefit Period. When the Deductible (if applicable) is applied to a Covered Service which has a maximum number of days or visits, the Benefit Maximum may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by us. Even after you satisfy the Out-of-Pocket Annual Maximum, our reimbursement remains limited by the Benefit Maximums of this plan even after the Out-of-Pocket Annual Maximum has been reached. See the “Schedule of Benefits” for those services which have a Benefit Maximum.

If you leave this Plan, and go on to a new Plan with us in the same Benefit Period, Covered Services that have a Benefit Maximum will be carried over to the new Plan. For example, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

Crediting Prior Plan Coverage

If you were covered by the Group’s prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket Limit amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group’s coverage with us began, or to people who join the Group later. Prior credit is not given at other times and is only given as part of the original enrollment of the employer group.

You must apply for the credit within 180 days if the Group’s effective date with us. If the information from the prior carrier gives clear detail that services were applied to the In-Network Deductible, credit will be given

towards your In-Network Deductible with us. If documentation is not available or is unclear credit will not be given under this Plan. For more specific information, please see your Human Resources or Benefits Department.

If you or your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), that has Deductible and Out-of-Pocket requirements, and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket Limit amounts, for the current Benefit Period, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, and approved by us, Out of Pocket amounts. Any maximums will be carried over and charged against maximums under this Plan. Credit is based on the particular plan design and may not be applied in all situations.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard," which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free-standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. HMO Nevada may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for Members, will give similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:

- You must be eligible for benefits;
- Premium must be paid for the time period that services are given;
- The service or supply must be a Covered Service under your Plan;
- The service cannot be subject to an Exclusion under your Plan; and
- You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
 - **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the postpartum individual and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay / Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/ Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage determination that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor (“requesting Provider”) will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	The Provider must get Precertification when required
Out of Network / Non-Participating	Member	<p>Member has no benefit coverage for an Out-of-Network Provider unless:</p> <ul style="list-style-type: none"> • The Member gets approval to use an Out-of-Network Provider before the service is given, or • The Member requires an Emergency Care admission (See note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> • The Member must get Precertification when required. (Call Member Services.) For an Emergency Care admission, precertification is not required. However, you, your authorized representative, or Doctor must tell us of the

Provider Network Status	Responsibility to Get Precertification	Comments
		<p>admission as soon as possible.</p> <ul style="list-style-type: none"> Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, services that are not Emergency Care services, or any charges in excess of the Maximum Allowed Amount.
BlueCard Provider	Member (Except for Inpatient Admissions)	<p>Member has no benefit coverage for a BlueCard Provider unless:</p> <ul style="list-style-type: none"> The Member gets approval to use a BlueCard Provider before the service is given, or, The Member requires an Emergency admission (See note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> The Member must get Precertification when required. (Call Member Services.) For an Emergency Care admission, Precertification is not required. However, you, your authorized representative, or Doctor must tell us of the admission as soon as possible. The Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, the services are not Emergency Care Services, or any charges in excess of the Maximum Allowed Amount. BlueCard Providers must obtain Precertification for all Inpatient Admissions.
<p>NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.</p>		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the “Grievance and External Review Procedures” section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	2 business days from the receipt of the request or more than two business days in accordance with Council for Affordable Quality Health Care (CAQH) guidelines
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

HMO Nevada may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an

alternate benefit if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because HMO Nevada exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that HMO Nevada will do so in the future or will do so in the future for any other Provider, claim or Member. HMO Nevada may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by checking your on-line Provider Directory or contacting the Member Services number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and HMO Nevada, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services." As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details.

Please note that care must be received from your Primary Care Physician (PCP) or another In-Network Provider to be a Covered Service under this Plan. If you use an Out-of-Network Provider, your entire claim will be denied unless:

- The services are for Emergency or Urgent Care; or
- The services are approved in advance by HMO Nevada as an Authorized Service

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;

- Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available or may be subject to benefit maximum limits.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Spectrum Disorder Services

Your Plan includes benefits for the screening, diagnosis, and treatment of autism spectrum disorder. Autism spectrum disorder is a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined. Coverage is provided for the screening, diagnosis, and treatment of autism spectrum disorder. In accordance with applicable law, the Plan will treat as dispositive a diagnosis of autism spectrum disorder that is rendered in accordance with the statewide standard for measuring outcomes and assessing Members with autism spectrum disorder until the Member reaches 21 years of age.

Screening for autism spectrum disorders means Medically Necessary assessments, evaluations or tests to screen and diagnose whether a Member has an autism spectrum disorder.

Treatment of autism spectrum disorders must be identified in a treatment plan and may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is Prescribed for a Member diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst or other healthcare provider as defined at N.R.S. § 629.031 that is acting within their scope of practice.

Solely as used in this autism spectrum disorders section, the following terms and definitions will apply:

Applied behavior analysis — the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Behavior or Behavioral therapy — any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization and provides behavioral therapy under the supervision of: (1) A licensed psychologist; (2) A licensed behavior analyst; or (3) A licensed assistant behavior analyst.

Evidence-based research — research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

Habilitative or rehabilitative care — counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

Licensed assistant behavior analyst — a person who holds current certification as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Applied Behavior Analysis and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

Licensed behavior analyst — a person who holds current as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Applied Behavior Analysis.

Prescription care — medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Psychiatric care — direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care — direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic care — services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

Treatment plan — a plan to treat an autism spectrum disorder that is developed by a licensed physician, licensed psychologist, or other healthcare provider as defined at N.R.S. § 629.031 that is acting within their scope of practice after they assessed the Member for whom the treatment plan is developed.

We may request a copy of and review the autism spectrum treatment plan. Services for autism spectrum disorder may be subject to Precertification. See the “Getting Approval for Benefits” section for details on Precertification.

Services for autism spectrum disorders are subject to the same general exclusions or limitations as other mental health services or prescription drugs covered by this Booklet.

Behavioral Health Services

Please see “Mental Health and Substance Use Disorder Services” later in this section.

Biomarker Testing

This Plan provides coverage for Medically Necessary Biomarker Testing when ordered by a Qualified Health Care Provider working within their scope of practice for the purpose of diagnosis, treatment, appropriate management, and ongoing monitoring of a Member’s cancer when the test is supported by medical and scientific evidence, including but not limited to: a) Labeled indications from an FDA-approved or cleared biomarker test or medication; b) Indicated tests for an FDA-approved Drug; c) Warnings and precautions on FDA-approved Drug label; d) Centers for Medicare and Medicaid Services' national coverage determinations; e) a local coverage determination as defined at 42 C.F.R. Section 400.202; or f) Nationally recognized clinical practice guidelines or Consensus statements.

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

- (1) An interaction between a gene and a drug that is being used by or considered for use by the patient;
- (2) A mutation or characteristic of a gene; and
- (3) The expression of a protein.

Biomarker Testing may require Precertification depending on the type of test. Member may be financially responsible for charges/costs related to Biomarker Testing in whole or in part if the service and/or setting is not found to be Medically Necessary.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services, when HMO Nevada approves the benefits in advance through Precertification. See “Getting Approval for Benefits” for details on the Precertification process. To be eligible for coverage at the In-Network level, services must be Medically Necessary and performed by an Approved In-Network Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain cellular and gene therapy services. Please call us to find out which providers are Approved In-Network Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section you will see some key terms, which are defined below:

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Services to you. The agreement may only cover certain Covered Services or all Covered Services. Approved In-Network Providers may include the following:

- **Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for care delivery of Covered Services.
- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery of Covered Services.

All Other Providers

Any Provider that is NOT an Approved In-Network Provider. This includes In-Network Providers who participate in the Plan’s networks, but who are not an Approved In-Network Provider for certain cellular or gene therapy services, as well as Out-of-Network Providers.

Transportation and Lodging Assistance

If you will need to travel more than 60 miles from your permanent home to reach the Facility where the Covered Services will be provided, we will cover the cost of reasonable and necessary travel costs when you get prior approval. Please see the “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell)” benefit for further details on travel coverage, and limits.

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

- i. Services determined to be Experimental / Investigational;
- ii. Services provided by a non-approved Provider or at a non-approved Facility; or
- iii. Services not approved in advance through Precertification.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an Approved Clinical Trial if the services are Covered Services under this Plan. An “Approved Clinical Trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated including, but not limited to, chronic fatigue syndrome.

Benefits are limited to the following Approved Clinical Trials:

- Federally funded trials approved or funded by one of the following:
 - The National Institutes of Health.
 - The Centers for Disease Control and Prevention.
 - The Agency for Health Care Research and Quality.
 - The Centers for Medicare & Medicaid Services.
 - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The Department of Veterans Affairs.
 - The Department of Defense.
 - The Department of Energy.
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- Studies or investigations done for drug trials, which are exempt from the investigational new drug application.
- Before participating in an Approved Clinical Trial, the Member has signed a statement of consent indicating that they have been informed of, without limitation: (a) the procedure to be undertaken; (b) alternative methods of treatment; and, (c) the risks associated with participation in the Approved Clinical Trial or, including, without limitation, the general nature and extent of such risks.

All requests for clinical trials services, including services that are not part of Approved Clinical Trials, will be reviewed according to our clinical coverage guidelines, related policies and procedures.

Coverage for medical treatment specified in this section is limited to:

- Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.
- Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of You, except this coverage shall not extend to the investigational item, device, or service that is the subject of the Approved Clinical Trial if that item, device, or service is provided to You free of charge.
- The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided under an Approved Clinical Trial or as a result of any complication arising out of the medical treatment provided in an Approved Clinical Trial, to the extent that such health care services would otherwise be covered under this Plan.
- The initial consultation to determine whether the Member is eligible to participate in the Approved Clinical Trial.
- Health care services required for the clinically appropriate monitoring of the Member during an Approved Clinical Trial.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Dental Anesthesia

Benefits are provided for general anesthesia, when provided in a Hospital, outpatient surgical facility or other facility, and for associated hospital or facility charges for dental care provided to a Dependent child who 1) has a physical, mental or medically compromising condition; 2) has dental needs for which local anesthesia is not effective because of acute infection, or allergy; 3) is extremely uncooperative, unmanageable, uncommunicative; or 4) has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Inpatient Admission for Dental Care

Benefits are provided for inpatient facility services including room and board, but do not include charges for the dental services, **only** if the member has a non-dental-related physical condition, such as bleeding disorders or heart condition that makes the hospitalization medically necessary.

Diabetes Equipment, Education, and Supplies

Your plan includes benefits for those who have insulin dependent diabetes, non-insulin dependent diabetes and elevated glucose levels induced by pregnancy or other medical conditions, when medically necessary.

Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, continuous glucose monitors and diabetic eye exams. Training and education are covered throughout the course of disease when provided by a certified, registered, or licensed health care professional with expertise in diabetes. Insulin pumps and related supplies are covered subject to meeting our medical policy criteria. Replacement of pumps that are out of warranty and are malfunctioning and cannot be refurbished would be a Covered Service. In situations where new models or upgrades to the latest insulin pump are requested, coverage would not be available.

When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits section and subject to the prescription cost share. Screenings for gestational diabetes are covered under "Preventive Care Services."

Continuous glucose monitors are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Medically Necessary genetic tests, when allowed by us.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission
- Medically Necessary genetic disease testing when allowed by Anthem's medical policy, except where this Booklet specifically covers and includes the test as part of another Covered Service Copayment or cost-share.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Breast Cancer Screening

Covered Services at no Cost Share include:

- Breast cancer including a mammogram annually for You if You are 40 years of age or older,
- An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by Your Provider based on personal or family medical history or additional factors that may increase the risk of breast cancer for You.
- A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by Your Provider to evaluate an abnormality which is: (i) seen or suspected from an annual mammogram screening for breast cancer; (ii) an imaging test described directly above this bullet point; or (iii) detected by other means of examination.

Dialysis

Please see “Therapy Services” later in this section.

Durable Medical Equipment (DME), Medical Devices, and Supplies

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes) when necessary to replace human lenses absent at birth or lost through intraocular surgery, ocular injury or for the treatment of keratoconus or aphakia. Replacements are only covered if a Physician recommends a change in prescription.
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment.
- Benefits are also available for cochlear implants, batteries, and cords.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood or blood products.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment. If you are experiencing a mental health crisis, you may also call 988 for assistance.

When you receive Covered Emergency Services (except ambulance services) from an Out-of-Network Provider, you will not be responsible for amounts in excess of the Maximum Allowed Amount.

Emergency Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Medical Condition)

“Emergency,” or “Emergency Medical Condition” means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient’s health or the health of another person in serious danger or, for a pregnant individual, placing the pregnant individual’s health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

“Emergency Care” means a medical or behavioral health exam within the capability of the Emergency Department of a Hospital or freestanding Emergency Facility, and includes ancillary services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. For Emergency Care you will not have to pay the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount.

For Surprise Billing Claims, the Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet. Your cost shares will be based on the Recognized Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following for the same or similar services:

- The amount negotiated with In-Network Providers for the Emergency service;

- The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing;
- The amount that would be paid under Medicare for the Emergency service; or
- The amount that must be paid under applicable law.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See “Getting Approval for Benefits” for more details.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for more details on how this will impact your benefits. Covered Services will not be available unless we agree to cover them as an Authorized Service.

Food and Nutrition

Your Plan includes coverage of nutrition therapy. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, durable medical equipment and pharmaceutical services. An In-Network licensed therapist or Home Health Care Agency must provide the nutrition services. All services must be precertified. Please see the “Getting Approval for Benefits” section for information on Precertification guidelines.

Enteral therapy and parenteral nutrition

Enteral nutrition is the delivery of nutrients orally, to the extent required by law, or by a tube into the gastrointestinal tract. TPN is the delivery of nutrients through an intravenous line directly into the bloodstream. Nursing visits to assist with enteral nutrition are covered when Medically Necessary and not considered custodial care under the “Home Health Care Services” benefit. These services are frequently provided through a home health agency.

Benefits are provided for enteral formulas for use at home that are prescribed or ordered by a Physician for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from Congenital Defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat metabolism. Special food products that are prescribed or ordered by a Physician as Medically Necessary are allowed. Coverage is provided whether or not the condition existed when coverage began under this Booklet.

Gender Affirming Care

This Plan provides coverage for policy coverage for the Medically Necessary treatment of conditions relating to Gender Dysphoria and gender incongruence. Covered Services, when approved as meeting Our criteria as Medically Necessary, may include, but are not limited to, psychosocial and surgical intervention and any other Medically Necessary treatment for such disorders provided by:

- Endocrinologists;
- Pediatric endocrinologists;
- Social workers;
- Psychiatrists;
- Psychologists;
- Gynecologists;

- Speech-language pathologists;
- Primary care physicians;
- Advanced practice registered nurses;
- Physician assistants; and
- Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

Some conditions and age restrictions apply, and all services must be authorized by Us.

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see "Therapy Services" later in this section for further details.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services (except for spinal Manipulation Therapy, which will not be covered when given in the home.)
- Medical supplies
- Durable medical equipment
- Private duty nursing services

Benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Use Disorder Services" section below.

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the “Inpatient Services” section below.

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital or outpatient care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member’s death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member’s death.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the current version of IRS Publication 502.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Childcare,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,

- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation,
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for eligible newborns during the pregnant or postpartum individual’s normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.

- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam for eligible newborns. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

*When available in your area, certain Providers have programs available that may allow you to receive Inpatient Services in your home instead of staying in a Hospital. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under "Home Health Care Services." Your Provider will contact you if you are eligible and provide you with details on how to enroll. If you choose to participate, the cost shares listed in your Schedule of Benefits under "Inpatient Services" will apply.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;
- Noninvasive Prenatal Screenings for certain genetic disorders. Precertification is not required;
- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the eligible newborn during the pregnant or postpartum individual's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services;
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us;
- Screenings for sexually transmitted infections in pregnant individuals as required by applicable law including rapid or point-of-care testing for syphilis; and

- Insertion of a long-acting reversible contraceptive device (implantable rods, copper-based intrauterine device, or progesterone-based intrauterine device) or injection of a contraceptive drug immediately following childbirth if requested by the Member when giving birth at a Hospital.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the pregnant or postpartum individual or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the postpartum individual's or newborn's attending Provider, after consulting with the postpartum individual, from discharging the postpartum individual or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include up to a 3-month initial supply, and up to a 9-month supply the second time the drug is dispensed (for up to the remainder of the Benefit Year). In subsequent Benefit Years under this Booklet, benefits include up to a 12-month supply (or refills for the months remaining in the Benefit Year) per prescription for the same contraceptive drug previously prescribed under this Booklet.

Covered contraceptives include oral contraceptive Drugs, injectable contraceptive Drugs, Self-Administered Hormonal Contraceptives, and patches or other Therapeutic Equivalent Contraceptive Drugs. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants, and the insertion of a contraceptive device and the removal of such device if the device was inserted while the Member was covered under the Booklet.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape. The Plan will also cover elective abortions.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
 - Observation and assessment by a physician weekly or more often,
 - Rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and Intensive In-Home Behavioral Health Services.
- **Virtual Visits** as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.
- **Medication-Assisted Treatment for Opioid Use Disorder** All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C),
- Any agency licensed by the state to give these services, when we have to cover them by law,
- A Behavioral Health and Wellness Practitioner licensed to practice Behavioral Health Promotion and Prevention, or
- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the “Autism Spectrum Disorders Services” section.

Certain medication assisted treatment may be available through a pharmacist who is duly licensed and registered to furnish such services in accordance with state law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by HMO Nevada.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor and Primary Care Provider visits in the home are different than the “Home Health Care Services” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Virtual Visits as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.

Prescription Drugs Administered in the Office

Hormone Replacement Therapy

Orthotics

See “Durable Medical Equipment (DME), Medical Devices, and Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,

- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force, or American Cancer Society guidelines, to the extent required by applicable law. Examples include screenings for:
 - Breast cancer, including a mammogram annually for You if You are 40 years of age or older please see “Diagnostic Services” earlier in this section for additional breast cancer diagnostic services.
 - Cervical cancer,
 - Colorectal cancer - This includes the preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),
 - High blood pressure,
 - Type 2 Diabetes Mellitus,
 - Cholesterol,
 - Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, and as required by applicable law, including:
 - a. Women’s contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives, spermicides, sponges and patches and over-the-counter oral contraceptives (including emergency contraceptives) and male condoms. Contraceptive devices such as diaphragms, contraceptive rings, cervical caps, intrauterine devices (IUDs), and implants are also covered. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at \$0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you

may obtain coverage of the Brand Drug with \$0 cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at \$0 cost sharing. Otherwise, Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

- b. Breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than one year. Benefits for breast pumps are limited to one pump per pregnancy.
 - c. Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care.
5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
- Counseling
 - Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy
 - Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over-the-counter (OTC) nicotine gum, lozenges and patches.
 - Not more than two cessation attempts per year and four counseling sessions per year.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
- Aspirin
 - Folic acid supplement
 - Bowel preparations
 - FDA-approved preexposure prophylaxis (PrEP), related services and monitoring including follow-up HIV testing and additional testing to monitor the effects of the PrEP medications.

Please note that certain age and gender and quantity limitations apply.

Your Plan includes additional benefits for:

- 1. Well-woman visits which includes at least one visit per year beginning at 14 years of age;
- 2. HPV testing, including Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older,
- 3. HPV vaccination as recommended by Centers for Disease Control and Prevention, the Food and Drug Administration (FDA), or the vaccine manufacturer,
- 4. Counseling for sexually transmitted infections, and counseling and screening for HIV,
- 5. Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;
- 6. Unrestricted coverage of condoms for members who are 13 years of age or older;
- 7. Screening and counseling for interpersonal and domestic violence for women at least annually with intervention services consisting of education, strategies to reduce harm, supportive services or a

Referral for any other appropriate services,

8. Screening for depression,
9. Services include those that meet the requirements of federal and state law including certain screenings, immunizations, all prescribed FDA approved contraceptives for women with reproductive capacity,
10. Screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing is required by applicable law,
11. Drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C that are prescribed, dispensed, and administered by a pharmacist in compliance with Nevada law regardless of whether the drug is included in the Anthem Prescription Drug List (a formulary developed by Anthem);
12. Laboratory testing that is ordered and performed by a pharmacist, in compliance with Nevada law, as necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;
13. Any service to test for, prevent, or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered by a specialist and:
 - a. The service is within the scope of practice of the provider of primary care, or
 - b. The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such a consultation.

You can find the current set of preventive benefits at <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/>.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's websites, <https://www.healthcare.gov/coverage/preventive-care-benefits/>, <https://www.ahrq.gov>, and <https://www.cdc.gov/vaccines/acip/index.html>.

Covered Services also include these services as required by state law, including, but not limited to, colorectal cancer, prostate cancer, and lung cancer screenings in accordance with the American Cancer Society:

- Routine or periodic exams, e.g., pelvic exams, Exams are covered according to the frequency determined by your Provider.
- Family history, current health problems and lifestyle all affect your risk for disease. Talk to your Provider to determine if you are at high risk for specific diseases and then together determine your appropriate exam schedule;
- Immunizations (including those required for school) and immunizations against cervical cancer or HPV to the extent required by applicable law. Immunizations protect you from certain diseases and help prevent epidemics. While immunization risks to your health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy;
- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider.
- Annual flu shot benefit when you receive a flu shot at your In-Network Provider's office. If it's more convenient to get your flu shot at a flu shot clinic or from an Out-of-Network Provider, you may be eligible for reimbursement of some or all of your out of pocket costs. Examples of locations that may provide flu shots and may be considered flu shot clinics include your local pharmacy, your place of employment, a grocery store, Wal-Mart, Walgreens or Costco. There may be additional flu shot clinic

locations available to you. For more information on flu shot clinics, how to obtain a claim form, and for the reimbursement amount allowed contact HMO Nevada's Member Services department or visit our website at www.anthem.com. The annual reimbursement is subject to change. Your cost for a flu shot otherwise paid for in full or in part by another party, is not eligible for reimbursement.

- Such other exams, screenings, supplies or counseling services, to the extent they are required by applicable law, to be covered as preventive care services.

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as "the agencies"). This includes care for the following chronic conditions:

Preventive Care	For Members Diagnosed With
Blood pressure monitor	Hypertension
Retinopathy screening	Diabetes
Peak flow meters	Asthma
Glucometers	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Statins	Heart disease and/or diabetes

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Sickle Cell Disease and Its Variants

Your Plan includes benefits for treatment of Sickle Cell Disease and Its Variants, including Medically Necessary prescription drugs and necessary care management services to assist patients in identifying and facilitating additional resources and treatments, to the extent required by law.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;

- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by a Congenital Defect or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

If reconstructive surgery is started within 3 years after a mastectomy, Members will have to pay the same Deductible, Coinsurance, and/or Copayments that applied to the surgeries in their Plan at the time of the mastectomy. If reconstructive surgery is begun more than 3 years after a mastectomy, Members will have to pay the same Deductible, Coinsurance, and/or Copayments that applied to surgeries in their Plan during that time.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, swallowing disorders in children and adults, and stuttering until the member reaches 26 years of age. Therapy will develop or treat communication, swallowing skills to correct a speech impairment, and stuttering until the member reaches 26 years of age.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.
- **Acupuncture** – Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular,

subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.

- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive Rehabilitation Therapy** – Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho- pulmonary drainage and breathing exercises.

Transplant Services

Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits (Telemedicine / Telehealth Visits)

Covered Services include virtual Telemedicine / Telehealth visits that are appropriately provided through the internet via video or telephone. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

- “Telemedicine / Telehealth” means the delivery of health care or other health services from a provider of health care to a patient at a different location using electronic communications and information technology, including live (synchronous) secure audio-visual communication and videoconferencing or secure instant messaging, store and forward (asynchronous) systems and audio-only interactions

(whether synchronous or asynchronous); but not including facsimile or electronic mail. This includes interactive store and forward (asynchronous) technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

Benefits do not include the use of facsimile, texting, electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to Providers outside our network, benefit Precertification, or Provider to Provider discussions except as approved under "Office and Home Visits."

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs including Specialty Drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, hormone replacement therapy to the extent required by law, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Use of an HMO Nevada Prescription Drug List (a formulary developed by HMO Nevada which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,

If You or Your doctor believes the step therapy protocol should be overridden in favor of immediate coverage of the doctor's selected Prescription Drug, please get in touch with us or have Your doctor get in touch with Us to request a step therapy exception.

Step therapy protocol will not be required when the Prescription Drug is prescribed to treat a psychiatric condition with knowledge, based on Your medical history or a reasonable expectation, that each alternative drug required to be used earlier in the step therapy protocol will be ineffective at treating the psychiatric condition.

We will respond to requests for step therapy exceptions within 2 business days of receiving all necessary information to conduct the step therapy review. If Your doctor indicates that exigent circumstances exist, we will respond within 24 hours. Our response will indicate whether the exception request is approved, denied or requires additional supplementation.

If the step therapy exception request is denied, You have the right to file an internal appeal as outlined in the "Grievance and External Review Procedures" section of this Booklet. If we fail to approve, deny or advise You or your prescribing Doctor that additional information is needed within 2 business days of receiving an internal appeal of the denial of a step therapy exception, or 24 hours in the case of exigent circumstances, the exception is deemed approved.

If an internal appeal for a step therapy exception is denied, You have the right to an external review of the denial as outlined in the “Grievance and External Review Procedures” section of this Booklet. The step therapy exception and appeals process is accessible through [anthem.com](https://www.anthem.com) under Grievance and Appeals. Go to [anthem.com/login](https://www.anthem.com/login) From the member dash-board page select support > message center > compose message > grievance/appeals>pharmacy, or you can go to [anthem.com/login](https://www.anthem.com/login), member>refer-auth, then click on File Appeal to submit your request.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound ingredients within a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section “Getting Approval for Benefits” for more details.

If Precertification is denied you have the right to file a Grievance as outlined in the “Grievance and External Review Procedures” section of this Booklet.

Designated Pharmacy Provider

HMO Nevada in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider’s office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider’s office.

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. HMO Nevada may,

from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Provider in a medical setting (e.g., doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if prior authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Use of a Prescription Drug List (as described below),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.

If You or Your doctor believes the step therapy protocol should be overridden in favor of immediate coverage of the doctor's selected Prescription Drug, please get in touch with us or have Your doctor get in touch with Us to request a step therapy exception.

Step therapy protocol will not be required when the Prescription Drug is prescribed to treat a psychiatric condition with knowledge, based on Your medical history or a reasonable expectation, that each alternative drug required to be used earlier in the step therapy protocol will be ineffective at treating the psychiatric condition.

We will respond to requests for step therapy exceptions within 2 business days of receiving all necessary information to conduct the step therapy review. If Your doctor indicates that exigent circumstances exist, we

will respond within 24 hours. Our response will indicate whether the exception request is approved, denied or requires additional supplementation.

If the step therapy exception request is denied, You have the right to file an internal appeal as outlined in the "Grievance and External Review Procedures" section of this Booklet. If we fail to approve, deny or advise You or your prescribing Doctor that additional information is needed within 2 business days of receiving an internal appeal of the denial of a step therapy exception, or 24 hours in the case of exigent circumstances, the exception is deemed approved.

If an internal appeal for a step therapy exception is denied, You have the right to an external review of the denial as outlined in the "Grievance and External Review Procedures" section of this Booklet. The step therapy exception and appeals process is accessible through anthem.com under Grievance and Appeals. Go to anthem.com/login. From the member dash-board page select support > message center > compose message > grievance/appeals>pharmacy, or you can go to anthem.com/login, member>refer-auth, then click on File Appeal to submit your request.

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

HMO Nevada may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services. If your prior authorization is for a Brand/Biologic agent, your authorization may be updated to a Generic/Biosimilar if one becomes available on the market before your authorization expires.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin according to state law and supplies and equipment used to administer insulin.
- Continuous glucose monitoring systems. ***Note:** Each component of the monitoring system will be subject to a separate Copayment / Coinsurance.
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). You may contact us to determine approved supplies covered through a pharmacy.
- Self-administered contraceptives, including oral contraceptive Drugs, Self-Administered Hormonal Contraceptives, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for

more details.

- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the “Preventive Care” benefit.
- Immunizations (including administration) required by the “Preventive Care” benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the “Preventive Care” benefit.
- FDA-approved smoking cessation products, including over-the-counter nicotine replacement products when obtained with a Prescription for a Member age 18 or older. These products will be covered under the “Preventive Care” benefit.
- Compound ingredients within compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Orally administered cancer chemotherapy drugs are covered according to state law.
- Hormone replacement therapy to the extent required by law.
- Medically Necessary Prescription Drugs for the treatment of Sickle Cell Disease and Its Variants to the extent required by law.
- Off label use of Prescription Drugs prescribed for the treatment of cancer if that use is specified in the most recent edition of, or supplement to:
 - a. The United States Pharmacopoeia Drug Information;
 - b. The American Hospital Formulary Service Drug Information; or
 - c. Supported by at least two articles reporting the results of scientific studies that are published in scientific or medical journals, as defined in 21 C.F.R. § 99.3.

No benefits are available for any Experimental drug used for the treatment of cancer if that drug has not been approved by the Food and Drug Administration, or use of a drug that is contraindicated by the Food and Drug Administration.

Where You Can Get Prescription Drugs

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy. If you get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and you may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When you go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), you pay a lower Copayment / Coinsurance on Covered Services than when you go to other In-Network Pharmacies.

Level 2 In-Network Pharmacies. When you go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), you pay a higher Copayment / Coinsurance on Covered Services than when you go to a Level 1 In-Network Pharmacy.

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any

Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Grievance and External Review Procedures” section of this Booklet.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Provider. We will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers we offer within 31 days, we will select a single In-Network Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Grievance and External Review Procedures” section of this Booklet.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Specialty Pharmacy

We keep a list of Specialty Drugs that may change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When you use the PBM's Specialty Pharmacy its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can have your Doctor send Prescriptions electronically, via fax or phone call, or you can submit written Prescriptions from your Doctor to the Home Delivery Pharmacy.

Home Delivery for Maintenance Medications – If you are taking a Maintenance Medication, you may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if you would like to keep getting your Maintenance Medications from your local Retail Pharmacy or if you would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication you get without registering your choice each year through the Home Delivery Pharmacy. You can tell us your choice by phone at the number on the back of your ID Card or by visiting our website at www.anthem.com.

A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

Please note: To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e. oral, injection, topical, or inhaled). We may cover one form of administration instead of another or put other forms of administration in a different tier.

Prescription Drug List

We also have an HMO Nevada Prescription Drug List, (a formulary), which is a list of Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over-the-counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage based upon medication dosage, dosage forms, manufacturer, and administration methods (i.e., oral, injection, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. We may add or remove drugs on the Prescription Drug List, or move drugs between tiers, to the extent permitted by law. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List:

If you or your Doctor believes you need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan. We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of your request or your Doctor's request for an exception will only be provided if you are a Member enrolled under the Plan.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. Early refills may also be available for synchronizing Chronic Medications as required by law, and Topical Ophthalmic Products as follows:

- After 21 days or more but before 30 days after receiving any 30-day supply of the product;
- After 42 days or more but before 60 days after receiving any 60-day supply of the product; or
- After 63 days or more but before 90 days after receiving any 90-day supply of the product.

We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. We will work with the Pharmacy to decide when this should happen. As used in this section, Chronic Medication means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely, or as defined by Nevada law. Topical Ophthalmic Product

means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a dropper, or as defined by Nevada law.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you out-of-pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Drug Cost Share Assistance Programs

If you qualify for non-needs-based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the Deductible, Copayment, or Coinsurance you pay for certain Specialty Drugs, the reduced amount you pay may be the amount we apply to your Deductible and/or Out-of-Pocket Limit.

In addition, we may also enroll you in a program, the Cost Relief Program, that allows you to further reduce your costs, and may eliminate your out-of-pocket costs altogether. We will work with manufacturers to get the maximum cost share assistance you are eligible for and will manage enrollment and renewals on your behalf.

Please note that Anthem may increase the cost share listed in the Schedule of Benefits in order to take full advantage of cost share assistance that is available from drug manufacturers. Any increase in the cost share will not be more than 50% of the Maximum Allowed Amount. This will lower plan costs but will not increase your cost because any additional cost share will be offset by the cost share assistance.

Participation in this program is voluntary. If you currently take one or more Prescription Drugs included in this program, we will automatically enroll you in the program and send you a welcome letter, followed up with a phone call that provides specific information about the program as it pertains to your medication. Whether you enroll in the Cost Relief Program or not, any non-needs based cost share assistance you receive will not accumulate to your Deductible or Out-of-Pocket Limit.

If you or a covered family member are not currently taking but will start a new Prescription Drug covered under this program, you can either contact us or we will proactively contact you so that you can take full advantage of the program.

Some drug manufacturers will require you to sign up to take advantage of the assistance that they provide. In those cases, we will contact you to let you know what you need to do.

The list of Prescription Drugs covered by the Cost Relief Program may be updated periodically by the Plan. Please refer to our website, www.anthem.com, for the latest list.

Opting Out

If you do not wish to participate in this program, you can opt out, and you will be responsible for a portion of the cost of the Specialty Drug as noted in the Schedule of Benefits.

Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over-the-counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

Rebate Impact on Prescription Drugs You get at Retail or Home Delivery Pharmacies

HMO Nevada and/or its PBM may also, from time to time, enter into agreements that result in HMO Nevada receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by HMO Nevada from rebates on Prescription Drugs purchased by you from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time you purchase the Prescription Drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim will not be adjusted if the later determined rebate value is higher or lower than our original estimate.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. **Administrative Charges**

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

2. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

3. **Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:**

- a) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
- b) Holistic medicine,
- c) Homeopathic medicine,
- d) Hypnosis,
- e) Aroma therapy,
- f) Massage and massage therapy, except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
- g) Reiki therapy,
- h) Herbal, vitamin or dietary products or therapies,
- i) Naturopathy,
- j) Thermography,
- k) Orthomolecular therapy,
- l) Contact reflex analysis,
- m) Bioenergetic synchronization technique (BEST),
- n) Iridology-study of the iris,
- o) Auditory integration therapy (AIT),
- p) Colonic irrigation,
- q) Magnetic innervation therapy,
- r) Electromagnetic therapy,
- s) Neurofeedback / Biofeedback.

4. **Adaptive Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.
5. **Autopsies** Autopsies and post-mortem testing.
6. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
7. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
8. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
9. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the “Consolidated Appropriations Act of 2021 Notice” in the front of this Booklet.
10. **Chats or Texts** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
11. **Chelating Agents** Services, supplies, or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.
12. **Clinical Trials Except as specifically stated as a Covered Service, this Plan does not provide coverage of:**
 - a) The Investigational item, device, or service.
 - b) Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
 - c) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
 - d) Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.
 - e) Any portion of the Approved Clinical Trial that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
 - f) A drug or device which is paid for by the manufacturer, distributor or provider of the drug or device including but not limited to the subject of the Approved Clinical Trial itself.
 - g) Health care services that are specifically excluded from coverage under this Booklet, regardless of whether such services are provided under the Approved Clinical Trial.
 - h) Extraneous expenses related to participation in the Approved Clinical Trial including, without limitation, travel, housing and other expenses that a participant may incur.
 - i) Any expenses incurred by a person who accompanies the Member during the Approved Clinical Trial.
 - j) Any costs for the management of research relating to the Approved Clinical Trial.
 - k) Non-health services required for you to receive treatment.
 - l) Costs that would not be a Covered Service under this Plan for non-Investigational treatments.
13. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

14. **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
15. **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
16. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
- This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.
17. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
18. **Crime** Treatment of an injury or illness that results from a felony you committed or tried to commit, and for which you have been convicted pursuant to applicable law. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition (including being intoxicated or under the influence of a controlled substance), or where you were the victim of a crime, including domestic violence.
19. **Cryopreservation** Charges associated with cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
20. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
21. **Delivery Charges** Charges for delivery of Prescription Drugs.
22. **Dental Devices for Snoring** Oral appliances for snoring.
23. **Dental Treatment** Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:
- a) Removing, restoring, or replacing teeth;
 - b) Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
 - c) Services to help dental clinical outcomes.
- Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.
- This Exclusion does not apply to services that we must cover by law.
24. **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
25. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
26. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
27. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

28. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
29. **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
30. **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal, routine pregnancy test, sore throat, earache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, or dental caries/cavity in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.
31. **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.
- The fact that a service or supply is the only available treatment will not make it a Covered Service if we conclude it is Experimental / Investigational.
32. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
33. **Eye Exercises** Orthoptics and vision therapy.
34. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
35. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
36. **Food and Nutrition**
- a) Enteral feedings.
 - b) Tube feeding formula except as provided elsewhere in this Booklet.
 - c) Weight-loss programs, exercise equipment, exercise classes, health club memberships, personal trainers, prescription or over-the-counter medications for weight loss, or obesity treatment even if the extra weight or obesity aggravates another condition.
 - d) Food, meals, formulas, and supplements other than those listed under Food and Nutrition in the "What's Covered" section even if the food, meal, formula or supplement is the sole source of nutrition, other than as provided above.
 - e) Breast feeding education, see "Preventive Care Services" section for coverage of breast feeding support.
 - f) Baby formulas.
 - g) Feeding clinics.
37. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
- a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.

- c) Other services that are given when there is not an illness, injury or symptom involving the foot.
38. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
39. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
40. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
41. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.
- If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
42. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
43. **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
44. **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
45. **Home Health Care**
- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
46. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
47. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
48. **Infertility Treatment** Testing or treatment related to infertility.
49. **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.
50. **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better. This exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
51. **Medical Equipment, Devices, and Supplies**
- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
 - d) Supplies, equipment and appliances, including wigs, that include comfort, luxury, or convenience

items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.

- e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
52. **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as required by federal law, as described in the section titled "Medicare" in "General Provisions". If you do not enroll in Medicare Parts A and/or B when you are eligible and Medicare would be primary (e.g., for Members in retiree plans or COBRA Members entitled to Medicare), we will calculate benefits as if you had enrolled. Please refer to medicare.gov for more details on when you should enroll.
53. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
54. **New Prescription Drugs, Indications, and/or Dosage Forms** New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and determined to be eligible for coverage by our Pharmacy and Therapeutics (P&T) Process.
55. **Non-Approved Drugs** Drugs not approved by the FDA.
56. **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
57. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
58. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over-the-counter and those you can get without a written Prescription or from a licensed pharmacist.
59. **Off Label Use** Off label use, unless we must cover it as part of the Covered Services under the "Clinical Trials" section, or in limited instances where we approve the use of the drug in the treatment of cancer.
60. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
61. **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care or Authorized Services.
62. **Personal Care, Convenience and Mobile/Wearable Devices**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
 - c) Home workout or therapy equipment, including treadmills and home gyms.
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypoallergenic pillows, mattresses, or waterbeds.
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
 - g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

63. **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
64. **Prosthetics** Prosthetics for sports or cosmetic purposes.
65. **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included.
 - d) Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health or Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.
66. **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” benefit.
67. **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.
68. **Self-Inflicted Injuries** Services or supplies necessitated by injuries which a Member intentionally self-inflicted, except if injury sustained by a Member is a consequence of being intoxicated or under the influence of a controlled substance, or except where the application of this exclusion is prohibited by applicable law.
69. **Services received from a Provider outside of Nevada.** This does not apply to:
- Emergency care or Urgent Care; or
 - Covered Services approved in advance by HMO Nevada.
70. **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, and Emergency Ambulance.
71. **Sexual Dysfunction** Services or supplies for male or female sexual problems.
72. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
73. **Sterilization** Services to reverse an elective sterilization.
74. **Surrogate Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). When a Member acts as a Gestational Carrier or Surrogate, the maternity coverage of the Member is not affected but the newborn child is not eligible for coverage under this Plan except as required by applicable law.
75. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

76. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
77. **Vision Services** Vision services not described as Covered Services in this Booklet.
78. **Waived Cost Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
79. **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
80. **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card or visit our website at www.anthem.com.
5. **Compound Ingredients** Compound ingredients that are not FDA-approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
9. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
13. **Drugs Shared by Member** Any Drug prescribed to member that is subsequently shared with other individuals.
14. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

15. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
16. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
17. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Cellular and Gene Therapy Services" benefit. Please see that section for details.
18. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
19. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
20. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
21. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment (DME), Devices, and Supplies" benefit. Please see that section for details.
22. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
23. **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.
24. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
25. **New Prescription Drugs, Indications, and/or Dosage Forms** New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and placed on a tier by our Pharmacy and Therapeutics (P&T) Process.
26. **NonApproved Drugs** Drugs not approved by the FDA.
27. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
28. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over-the-counter and those you can get without a written Prescription or from a licensed pharmacist.
29. **Off Label Use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
30. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
31. **Over-the-Counter Items** Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-

counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over-the-counter.

This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.

- 32. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
- 33. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- 34. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. **Please remember that this Plan will not provide benefits for services from Out-of-Network Providers unless the claim is for Emergency Care, Urgent Care or for services approved in advance by HMO Nevada as an Authorized Service.**

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangements" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable precertification, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, or when allowed as a result of a Referral by us. Except for Surprise Billing Claims*, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

**Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Please refer to that section for further details.*

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules, reimbursement policies, and/or reimbursement requirements. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent

procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

NOTE: We will apply the In-Network level of benefits and the Member will not be required to pay more for the services than if the services had been received from an In-Network provider in the following circumstances:

1. Emergency Care;
2. Where in-patient hospital care at an Out-of-Network Hospital is necessary due to the nature of the treatment;
3. Where in-patient hospital care at an Out-of-Network Hospital is necessary due to In-Network Provider Hospital capacity;
4. When a Member has received a precertified network exception, under the Authorized Services paragraph below.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Medical Excellence or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by us as result of a Referral.

For Covered Services you receive from an Out-of-Network Provider for Emergency Care or for services approved as a Referral, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our managed care fee schedules used with In-Network Providers, which we reserve the right to modify from time to time; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, HMO Nevada will update such information, which is adjusted or unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third-party vendor, which has been agreed to by the Provider. This may

include rates for services coordinated through case management, or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider; or
6. An amount required by applicable law.

Providers who are not contracted for this product but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the six methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside HMO Nevada's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the HMO Nevada Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Provider may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount unless your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. Please see the "How Your Plan Works" section for further information on Authorized Services requirements. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your

claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

HMO Nevada has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, you can send a written request to us or contact Member Services and ask for a claim form to be sent to you. The same information that would be given on the claim form must be included in the written notice of claim, including:
 - Name of patient.
 - Patient's relationship with the Subscriber.
 - Identification number.
 - Date, type, and place of service.
 - Your signature and the Provider's signature.

Out-of-Network claims must be submitted within 180 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180 day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate you will be responsible for any charge for services.

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. Where permitted by applicable law, we reserve the right to make payments directly to you as opposed to any Provider for Covered Services, at our discretion, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, we will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "HMO Nevada Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the HMO Nevada Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

HMO Nevada covers only limited healthcare services received outside of the HMO Nevada Service Area. For example, Emergency or Urgent Care obtained outside the HMO Nevada Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by HMO Nevada.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard[®] Program

Under the BlueCard[®] Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the HMO Nevada Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard[®] Program

If you receive Covered Services under a Value-Based Program inside a Host Blue’s Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to HMO Nevada through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of HMO Nevada's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the HMO Nevada Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency, including ambulance, outside of the United States. Remember to take an up-to-date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting Approval for Benefits" section in this Booklet for further information.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits When Members Are Insured Under More Than One Plan

We coordinate benefits when you have duplicate coverage.

Duplicate Coverage - Duplicate coverage exists when you are covered by this coverage and also covered by another group or group-type health insurance or health benefits coverage or blanket coverage, or where permitted by law, an individual insurance policy. The total benefits received by you, or on your behalf, from all coverage's combined for any claim for Covered Services will not exceed 100 percent of the total covered charges.

Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering the Member. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging the Member is not an allowable expense.

The following are not allowable expense:

- The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses.
- If the Member is covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
- If the Member is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the highest of the negotiated rates.
- If the Member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.
- However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- The amount of any benefit reduction by the primary plan because the Member failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- If the Member advises HMO Nevada that all plans covering the Member are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and the Member intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

How We Determine Which Coverage is Primary and Which is Secondary – We will determine the primary coverage and secondary coverage according to the following rule: A coverage is primary if it does not have order of benefit determination rules or if it has rules that differ from those permitted by state law.

The amount that is subject to the Primary high-deductible health plan's deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Duplicate Coverage on Members - A coverage is primary if the Member claiming benefits is the person in whose name the policy is issued but who is not a Dependent under that coverage (except when covered by Medicare or COBRA).

The benefits of a coverage which covers a person as an employee who is not laid-off or retired (or as that employee's Dependent) is primary before benefits of a coverage which covers that person as a laid-off or retired employee (or as that employee's Dependent).

When you (including your Dependent family Members) have duplicate coverage carried through two or more employers, the policy that has been in force the longest period of time is primary. The policy that has been in force the shortest period of time is secondary.

When the coverage through one of the employers is a COBRA policy and one of the coverage's is through active employment, the coverage through active employment is primary.

NOTE: Change in plan administrators is considered continuous coverage. Therefore, the Effective Date of the coverage in that group is the Effective Date with the original carrier who provided insurance or the original administrator for self-funded plans, as long as there were no lapses in coverage. Information about coordinating benefits for Members who hold two insurance policies and Medicare may be found under the "Members with Medicare and Two Group Insurance Policies" heading in this section of this Benefit Booklet.

Duplicate Coverage on Spouses - When your Spouse has group coverage through an employer and is actively working, that coverage is primary for the Spouse.

When the coverage carried by the Spouse is through retiree or inactive employment, that coverage will be primary over the coverage carried by our Subscriber.

When the Spouse's coverage through the employer is a COBRA policy and our coverage is active, then the Spouse's COBRA coverage will be secondary to us.

Note: Information about coordinating benefits for Members who hold two insurance policies and Medicare may be found under the heading "Members with Medicare and Two Group Insurance Policies" heading in this section.

Duplicate Coverage on Dependent Children (when parents are not separated or divorced) - If both coverages cover the child as a Dependent, the benefits of the coverage of the parent whose birthday occurs earlier in the year is primary ("Birthday Rule") over those of the coverage of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the coverage that has covered **the parent** and Dependent(s) longest is primary over the coverage which has covered the **other parent** and Dependent(s) for a shorter period of time.

If either form of coverage does not follow the Birthday Rule, the male subscriber's insurance or plan is the primary Plan.

Duplicate Coverage on Dependent Children (when parents are separated or divorced) – We require a copy of the divorce decree to establish primacy on children of divorced parents.

When the specific terms of a court decree state that one of the parents is responsible for providing health insurance for the child that insurance policy is primary. The insurance policy of the other parent is the secondary coverage.

The insurance policy or plan of the parent with legal custody of the child is primary. When the parent with custody remarries, the custodial parent's coverage remains primary. The stepparent's coverage becomes secondary, and the coverage of the parent without custody pays **after** the stepparent's coverage.

The Birthday Rule (benefits of the coverage of the parent whose birthday occurs earlier in the year are primary) applies when the specific terms of the court decree state that the parents share joint custody and both must provide health benefits.

The Birthday Rule applies when the specific terms of the court decree state that the parents share joint custody, without stating which parent is responsible for providing health benefits for the child.

When the divorce decree states that one of the parents is responsible for providing health insurance and the parents share joint custody, then the parent providing the coverage will be primary.

Members with a Stand-Alone Dental Policy - For Covered Services provided by an Oral and Maxillofacial Surgeon, the Plan will be secondary for when the Member is covered under a Stand-Alone Dental Policy. "Oral and Maxillofacial Surgeon" means a dentist who has been issued a specialist's license to practice oral and maxillofacial surgery pursuant to NRS 631.250 and who provides any of the services described in paragraph (c) of subsection 1 of NRS 631.215. "Stand-Alone Dental Policy" means any policy which only pays for or reimburses any part of the cost of dental care, as defined in NRS 695D.030, and is offered or issued separately from a policy of health insurance.

How We Coordinate Benefits - When we are the primary coverage, including if you have other coverage under an individual policy of insurance, we pay benefits under the terms of this Benefit Booklet. When we are the secondary coverage, we may pay up to the difference between benefits that would be payable by the primary coverage and the amount that would be payable under this Benefit Booklet in the absence of a Coordination of Benefits provision, so long as that difference is not more than this Plan would normally pay. Benefits provided under any other coverage include benefits that would have been provided had a claim been made for these benefits.

Determining Primacy Between Medicare and this Plan – We will be the primary payer for persons age 65 and older with Medicare coverage if the Subscriber is actively working for an employer who is providing the Subscriber's health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons age 65 and older with Medicare coverage if the Subscriber is not actively working and the member is enrolled in Medicare. Medicare will be the primary payer for persons with Medicare age 65 and older if the employer has less than 20 employees and the member is enrolled in Medicare.

This Plan will be the primary payer for persons under age 65 with Medicare coverage when Medicare coverage is due to disability if the member is actively working for an employer who is providing the member's health coverage and the employer has 100 or more employees. Medicare will be the primary payer for persons enrolled with Medicare due to disability if the member is not actively working or the employer has less than 100 employees.

This Plan will be the primary payer for persons under age 65 with Medicare coverage when Medicare coverage is due to End Stage Renal Disease (ESRD), for the first 30 months from the **entitlement to or eligibility for** Medicare (whether or not Medicare is taken at that time). After 30 months, Medicare will become the primary payer if Medicare is in effect (30-month coordination period).

When a Member becomes eligible for Medicare due to a second entitlement (such as age), we remain primary, if we were primary at the point when the second entitlement became effective, for the duration of 30 months after the Medicare entitlement or eligibility due to ESRD. If Medicare was primary at the point of the second entitlement, then Medicare remains primary. There will be no 30-month coordination period for ESRD.

Members with Medicare and Two Group Insurance Policies - If Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the Member will pay first, Medicare will pay second, and the coverage covering the Member as a retiree or inactive employee or Dependent will pay third. The order of primacy is not based on the group health insurance subscriber.

If Medicare is the primary payer due to Medicare primacy rules, then the rules of primacy for employees and their Spouses will be used to determine the coverage that will pay second and third. The rules of primacy can be found under the heading "Double Coverage on Spouses."

Your Obligations – You have an obligation to provide us with current and accurate information regarding the existence of other coverage.

Benefits payable under another coverage include benefits that would be payable under that coverage, whether or not a claim is made, and benefits that would have been paid but were refused because the claim was not sent to the Provider of other coverage on a timely basis.

Your benefits under this Benefit Booklet will be reduced by the amount that such benefits would duplicate benefits payable under the primary coverage.

HMO Nevada's Rights to Receive and Release Necessary Information – We may release to, or obtain, from any insurance company or other organization or person any information which we may need to carry out the terms of this Booklet. Members will furnish to us such information as may be necessary to carry out the terms of this Booklet.

Payment of Benefits to Others - Whenever payments that should have been made under this Benefit Booklet have been made under any other coverage, we will have the right to pay to the other coverage any amount we determine to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Benefit Booklet, and with that payment we will fully satisfy our liability under this provision.

Right of Overpayment Recovery - If we have overpaid for Covered Services under this provision, we will have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or on whose behalf, the payments were made.

Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness and another party(ies) agrees or is ordered to pay money because of these injuries or when the member has received or is entitled to receive a recovery because of these injuries or illnesses.

Subrogation

We have the right to recover payments we make on the Member's behalf. Except where prohibited by law or regulation, the following applies:

- We have a lien for the full amount of benefits we have paid from any recovery, including, but not limited to, the other party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. We will not seek to recover payments from individual health insurance, health insurance under a franchise plan, no-fault automobile insurance, automobile medical insurance or any other first-party coverage of the member.
- The Member and the Member's legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them.
- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid under this Benefit Booklet.
- We are not responsible for any attorney fees, other expenses or costs incurred without our prior written consent.

Right of Reimbursement

If the Member, the Member's legal representative, or beneficiary obtain a recovery sufficient to satisfy in full the Member's claim against the third party(ies) and we have not been repaid for the benefits we paid on the Member's behalf, we shall have a lien right to be repaid from the recovery in the amount of the benefits paid on the member's behalf and the following apply:

- Once the Member is made whole, the Member must reimburse us to the extent of benefits we paid on the Member's behalf from any recovery, including, but not limited to, the other party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. We will not seek to recover payments from individual health insurance, health insurance under a franchise plan, no-fault automobile insurance, automobile medical insurance or any other first-party coverage of the member.
- Notwithstanding any allocation made in a settlement agreement, we shall have a right of reimbursement against any recovery.

The Member's Duties

- The Member, the Member's legal representative, or beneficiary must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to the Member occurred and all information regarding the parties involved or any other information requested by us.
- The Member, the Member's legal representative, or beneficiary must cooperate with us in the investigation, settlement and protection of our rights.

- The Member, the Member's legal representative, or beneficiary must not do anything to prejudice our rights.
- Upon request, the Member, the Member's legal representative, or beneficiary must send us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness.
- The Member, the Member's legal representative, or beneficiary must promptly notify us if the Member retains an attorney or if a lawsuit is filed.
- The Member, the Member's legal representative, or beneficiary must immediately notify us if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance, which is defined as follows:

This section explains what to do if you disagree with our denial, in whole or in part, of a claim, requested service or supply, and how to file a Complaint, Appeal or Grievance with us.

Complaints

If you have a Complaint about any aspect of our services or claims processing, you should contact our Member Services department or write us at:

HMO Nevada
700 Broadway
Denver, CO 80273

If you have questions regarding eligibility or Membership, contact our Member Services department or write us at:

HMO Nevada
P.O. Box 172405
Denver, CO 80217-2405

A trained representative will work to clear up any confusion and resolve your concerns. If you are not satisfied with the resolution, you can file an Appeal as explained under the "Appeals" heading in this section.

Appeals

While we encourage you to file Appeals within 60 days of the adverse benefit determination, the written or oral Appeal must be received by us within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. We will assign an employee to assist you in the Appeal process. You may send written Appeals to the following address:

HMO Nevada Appeals Department
700 Broadway
Denver, CO 80273

The Appeal must state plainly the reason(s) why you disagree with our claim decision, refusal to authorize or cover a requested service or supply, or how we calculated the benefit. You should include any documents not originally submitted with the claim or request for the service or supply and any other information that you feel may have a bearing on the decision.

Through the Appeal process, you can access two levels of Appeal, and, where appropriate, independent external review. You can designate a representative (e.g., your Physician or anyone else of your choosing) to assist you with filing any level of Appeal. In some instances, we may ask you to designate your representative in writing. You or your representative can review the Appeal file on request, and can present evidence as part of the Appeal process. If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale.

First Level Appeal — This is an Appeal in which the HMO Nevada Appeal Board reviews the Appeal and makes a determination. The majority of the Appeal Board are Members who receive health care benefits from us and who were not involved in the initial adverse benefit determination, but a person who was previously involved with the denial may answer questions. The Appeal Board will make its determination within 30 days after receipt of the Appeal, unless you agree to a longer period. You will receive written notification of the Appeal Board's determination, with the reasons for its decision.

Second Level Appeal — If the First Level Appeal decision is not satisfactory, you can (but do not have to) file a Second Level Appeal. You have 60 days from receiving the First Level Appeal decision in which to request a Second Level Appeal. The panel of the Second Level Appeal Board includes a minimum of three people. The majority of the Second Level Appeal Board are Members who receive health care benefits from us. At the Second Level Appeal, you or your representative may appear or be teleconferenced in to present information.

We will provide you with a copy of the Second Level Appeal Board's written decision within 30 days after receipt of the Appeal request, unless you agree to a longer period of time. We will provide a copy of the decision to any Provider who submits a Second Level Appeal on your behalf.

Expedited First Level Appeal — You or your representative have the right to request an expedited Appeal when the time frames for a standard review could: (1) seriously jeopardize your life or health; (2) jeopardize your ability to regain maximum function; or (3) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Expedited Appeals will be resolved as quickly as medical circumstances require, but not later than 72 hours after receipt of the request. Except as mentioned below, expedited Appeals are not available when the service or supply in question has already been provided to you.

Independent External Review Appeal — If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may have the right to Independent External Review, where our decision will be reviewed by health care professionals who have no association with us. You may also request an Independent External Review when a claim has been denied based upon a determination that the recommended or requested health care service or treatment is experimental or investigational treatment. Except as noted below, in order to request an Independent External Review, you must have first completed a First Level Appeal, but you can make such a request either after or instead of choosing to file a Second Level Appeal. But if we fail to respond to a Complaint or Appeal within thirty (30) calendar days, and you have not agreed to an extension, you can request an Independent External Review and you will be considered to have exhausted the internal Appeals process. Also, in some instances, we may (but are not required to) agree to an Independent External Review even if you have not exhausted the First Level Appeal. If we fail to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

The request for Independent External Review must be made to the Nevada Office for Consumer Health Assistance within four months after the adverse benefit determination or our final Appeal determination, whichever is later. Except as mentioned below for expedited external review Appeals, the request must be in writing on a form available through the Office of Consumer Health Assistance, which can be contacted at:

E-mail: cha@govcha.nv.gov

Fax: (702) 486-1597

- Within 5 business days after receiving the request for external review, the Office for Consumer Health Assistance shall notify you, us and other interested parties that a request for external review has been filed.

- As soon as practical, the Office for Consumer Health Assistance shall assign the Independent Review Organization.
- Within 5 business days after receiving the assignment from the Office for Consumer Health Assistance identifying the Independent Review Organization, we shall provide all documents and materials relating to the adverse determination to the Independent Review Organization.
- Within 5 days after receiving notification from the Office for Consumer Health Assistance and the materials from us, the Independent Review Organization will review the materials and notify you if additional information is needed to conduct the review.
- Additional information must be provided within 5 days after receiving the request.
- The Independent Review Organization shall forward a copy of the additional information to us within 1 business day after receipt.
- Within 15 days of completing the review, the Independent Review Organization shall submit a copy of its determination to you.

When you or your representative request Independent External Review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for Independent External Review. If your claim is determined to be not eligible for Independent External Review, you will be notified of that decision. However, if your denial is eligible for Independent External Review, an Independent Review Organization will be assigned to conduct the review and issue a decision.

Expedited Independent External Review Appeals — An expedited review may be requested from the Office for Consumer Health Assistance when: (1) an adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the services or care; or (2) failure to proceed in an expedited manner may jeopardize your life or health or your ability to regain maximum function; or (3) if the claim has been denied based upon a determination that the service or treatment is experimental or investigational, your treating Physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated.

Typically, you must complete a First Level Appeal prior to requesting external review. However, if the adverse determination involves a denial based on a determination that the service or treatment is experimental or investigational and the treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, and, if you have a medical condition where the time to complete an Expedited First Level Appeal would seriously jeopardize your life, health or ability to regain maximum function, then you or your representative can request Expedited Independent External Review at the same time as requesting an Expedited First Level Appeal. If eligible for Expedited Independent External Review, the Independent Review Organization assigned to your case will then determine whether the Independent External Review should be decided before your Expedited First Level Appeal.

- The Office for Consumer Health Assistance shall approve or deny a request for an expedited external review within 72 hours after it receives proof of whether the request qualifies for expedited external review.
- Upon determination that the request is eligible for an expedited external review, Office for Consumer Health Assistance shall assign an Independent Review Organization within 1 working day after approving the request.
- We shall provide all documents and information used to make the adverse determination to the

Independent Review Organization within 24 hours after receiving notice from the Office for Consumer Health Assistance assigning the request.

- The Independent Review Organization must complete its review within 48 hours (unless you and HMO Nevada agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the Independent Review Organization must notify you, Physician and HMO Nevada of its determination by telephone, followed up in writing within 48 hours.

You or your provider can request (orally or in writing) an Expedited Independent External Review. Requests for Expedited Independent External Review must be made to the Office for Consumer Health Assistance within four months of an adverse benefit determination or our final Appeal determination, whichever is later. The Office for Consumer Health Assistance can be reached at:

E-mail: cha@govcha.nv.gov

Fax: (702) 486-1597

When you or your representative request Independent External Review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for Independent External Review. If your claim is determined to be not eligible for Independent External Review, you will be notified of that decision. However, if your denial is eligible for Independent External Review, an Independent Review Organization will be assigned to conduct the review and issue a decision

Appeals Involving Independent Medical Evaluations - If we require an independent medical, dental, or chiropractic evaluation to make a final determination of benefits or care, we may require you to submit to the independent medical evaluation. The evaluation will be conducted by a Physician, Dentist, or chiropractor who is certified to practice in the same field of practice as the primary treating Physician, Dentist, or chiropractor, or who is formally educated in that field.

The independent evaluation must include a physical examination of the patient, unless deceased, and a personal review of all x-rays and reports prepared by the primary treating Physician, Dentist, or chiropractor. A certified copy of all reports of findings must be sent to the primary treating Physician, Dentist, or chiropractor and you within 10 working days after the evaluation. If you disagree with the findings of the evaluation, you must submit an Appeal to HMO Nevada, pursuant to the procedure for binding arbitration as established by the American Arbitration Association, within 30 days after receipt of the findings of the evaluation. Upon receipt of an Appeal, we will notify the primary treating Physician, Dentist, or chiropractor in writing.

We will not limit or deny coverage for care related to a disputed claim that requires an independent medical evaluation while the dispute is in arbitration. However, if we prevail in the arbitration, the primary treating Physician, Dentist, or chiropractor may not recover any payment from us, the subscriber or the patient for services that the Physician, Dentist, or chiropractor provided to the patient after receiving written notice from us.

Grievances

You may send a written Grievance to the following address within 60 days of the event:

HMO Nevada Quality Management Department
700 Broadway
Denver, CO 80273

Our Quality Management Department will acknowledge receipt of, and investigate, your Grievance. We treat each Grievance investigation in a strictly confidential manner.

Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced within three years of our final decision on the claim or other request for benefits. If we decide Appeal is untimely, our decision on the claim or other request for benefits from which the Appeal was taken shall be considered our final decision, and the three-year period in which a lawsuit or legal action must be brought shall run from the date of that final decision, not the date on which Anthem decided the Appeal was untimely. You must exhaust the internal Appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against us. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your Appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within three years of the internal Appeal decision.

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List" section in "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for the process to submit an exception request for Drugs not on the Prescription Drug List.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and perform the duties of your principal occupation for the Group; and
- Reside or work in the service area(s) noted in the “Schedule of Benefits”.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse as recognized by either state or federal law. For information on spousal eligibility please contact the Group.
- The Subscriber's Domestic Partner, if Domestic Partner coverage is allowed under the Group's Plan. Please contact the Group to determine if Domestic Partners are eligible under this Plan. Domestic Partner, or Domestic Partnership means:
 - A person of the same or opposite sex;
 - Has a common residence with the Subscriber;
 - Is neither married nor a member of another domestic partnership;
 - Is not related to the Subscriber by blood closer than permitted by state law for marriage;
 - Is at least 18 years of age; and
 - Competent to consent to the domestic partnerships.

It also includes relationships, regardless of how named, which state law recognizes as a valid domestic partnership.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must have filed with the state of Nevada a signed and notarized statement and have paid all filing fees and associated administrative costs where such a statement or costs are required. A completed Enrollment Application must also be sent to us.

We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law. However, this does not include a newborn child conceived or delivered by the Member while acting as a Gestational Carrier or Surrogate.
- Children, including grandchildren, for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law. Grandchildren may be covered for the first 31 days after birth as long as the parent is covered as a Dependent child under this Booklet. For coverage to continue beyond the first 31 days after birth, the Subscriber or the Subscriber's spouse must be the court-appointed permanent guardian for the grandchild.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to an intellectual or physical impairment. The Dependent's impairment must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. A completed Mentally or Physically Impaired Form must be submitted. The Subscriber and the impaired Dependent's physician must complete this form and submit it to us. You may call us at the number at the back of your ID card to get a form. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; or Domestic Partner;
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group and will not exceed 90 days. The Group will inform you of the length of the waiting period. No services before that effective date will be covered. We must receive an application / change form within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described below.

Note: Submission of an application / change form does not guarantee member enrollment.

Open Enrollment

Open Enrollment refers to a period of time, usually 31 days prior to the Group's renewal date, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are not considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth, to the extent required by applicable law. Covered Services consist of medically necessary care for injury and sickness, including care and treatment of medically diagnosed Congenital Defects and birth abnormalities. All services provided during the first 31 days of coverage are subject to the cost sharing requirements that are applicable to other sicknesses, diseases and conditions otherwise covered. Following the birth an eligible child, you should submit an application / change form to the Group within 31 days to add the newborn to your Plan.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

A newborn child, delivered by a Member who acts as a Gestational Carrier or Surrogate, will be deemed to be the child of the Intended Parent, and not the child of the Member. This means that the newborn child will not be eligible to be added as a Dependent under this Plan, will not be covered under this Plan except where required by applicable law and may need to secure coverage under the Intended Parent's plan or a separate individual health benefit plan.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for 31 days after the date of placement for adoption. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;

- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.
- When the Member moves and therefore neither resides nor works within the Service Area, unless the Member is continuing coverage under COBRA continuation. The Member must notify HMO Nevada within 31 days of such a change in location. Coverage will end on the last day of the month in which the change of residence is reported; until that time, the only out-of-area services covered will be emergency care. Non-emergency care will not be covered.
- If a Member does not notify HMO Nevada of a change of residence or workplace to an area outside of the service area, and HMO Nevada later becomes aware of the change, the Member's coverage may be retroactively terminated to the date of the change of residence or place of employment. The Member will be liable to HMO Nevada and/or the providers for payment for any services covered in error.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Subscribers: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Dependents: A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months

Qualifying Event	Length of Availability of Coverage
Death of a Covered Subscriber	36 months
For Dependent Children:	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/agencies/ebsa (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

Total Disability Coverage

Coverage may continue for a Subscriber and covered Dependents while the Subscriber is on leave without pay due to a total disability. Coverage under this provision continues until the earliest of the following:

- Twelve months from the date that coverage began under this provision.
- The date on which the Subscriber's employment is terminated.
- The date on which the employer master contract is terminated.
- The date on which the Subscriber obtains other health care benefits or health care insurance.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of

health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

- The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - 14 days after completing military service for leaves of 31 to 180 days,
 - 90 days after completing military service for leaves of more than 180 days; or
- 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

- The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
- 14 days of completing your military service for leaves of 31 to 180 days; or
- 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

- Two years; or
- As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting / probationary periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work

without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

Benefits After Termination Of Coverage

Except as provided below, we will not pay for any services provided after your coverage ends even if precertification was received. Benefits cease on the date your coverage ends as described above. You may be liable for benefit payments made by us on your behalf for services provided after your coverage has terminated, even if the termination was retroactive.

We are only liable for payment of expenses for covered services provided during the effective period of this Plan. We are not liable for expenses incurred after coverage under this Plan is terminated or following any amendment(s) made to this Plan in accordance with applicable law that may affect a change in such payment. You may be liable for benefit payments made on your behalf for services provided after your coverage has terminated.

We do not cover services received after your date of termination even if:

- We precertified the services.
- The services were made necessary by an accident, illness or other event that occurred while coverage was in effect.
- The member was hospitalized at the time of termination.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond our control, we may be unable to process Member claims on a timely basis. No legal action or lawsuit may be taken against us due to a delay caused by any of these events.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with HMO Nevada

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, HMO Colorado, Inc. dba HMO Nevada, and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Nevada. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than HMO Nevada and that no person, entity, or organization other than HMO Nevada shall be held accountable or liable to the Group for any of HMO Nevada's obligations to the Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of HMO Nevada.

Fraudulent Insurance Acts

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

Insurance fraud results in cost increases for health care coverage. Members can help decrease these costs by doing the following:

- Be wary of offers to waive copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from HMO Nevada. If there are any discrepancies, call HMO Nevada's Member Services department at the number on your ID card.
- Be very cautious about giving the member's health insurance coverage information over the phone.

If fraud is suspected, you should contact HMO Nevada's Member Services department at the number your ID card.

We reserve the right to recoup any benefit payments paid on behalf of a Member if the Member has committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

HMO Nevada reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of HMO Nevada's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including HMO Nevada's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan, do not duplicate any benefit for which Members are entitled to or enrolled in under Medicare, including Parts A and/or B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. If you do not enroll in Medicare Parts A and/or B when you are eligible, and Medicare would be primary (e.g., for Members in retiree plans or COBRA Members entitled to Medicare), we will calculate benefits as if you had enrolled. Please refer to [Medicare.gov](https://www.medicare.gov) for more details on when you should enroll.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem Blue Cross and Blue Shield has adopted a Members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to www.anthem.com and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

No Withholding of Coverage for Necessary Care

We do not compensate, reward or incent, financially or otherwise, our associates for inappropriate restrictions of care. HMO Nevada does not promote or otherwise provide an incentive to employees or physician reviewers for withholding benefit approval for Medically Necessary services to which the Member is entitled. Utilization review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this Certificate.

HMO Nevada does not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of authorization for coverage; (2) reductions or limitations on hospital lengths of stay, medical services or charges; or (3) telephone calls or other contacts with health care providers or members.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against HMO Nevada based on the actions of a Provider of health care, services, or supplies.

Paragraph Headings

The headings used throughout this Booklet are for reference only and are not to be used by themselves for interpreting the provisions of the Booklet.

Payment Innovation Programs

We pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies, Procedures, and Pilot Programs

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives that may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. We may also offer, at our discretion, the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost-effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Group-Member-HMO Nevada)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (HMO Nevada and In-Network Providers)

The relationship between HMO Nevada and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is HMO Nevada, or any employee of HMO Nevada, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or Referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Research Fees

HMO Nevada reserves the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to the Member in explanations of benefits, letters or other documents.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowed Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Reserve Funds

No Member is entitled to share in any reserve or other funds that may be accumulated or established by HMO Nevada, unless HMO Nevada grants a right to share in such funds.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We reserve the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Sending Notices

All Subscriber notices are considered sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either:

- The Subscriber at the latest address in HMO Nevada's membership records.
- The Subscriber's employer, if applicable.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public.

Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the

recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of HMO Nevada, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or make payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Appeal

A process for reconsideration of HMO Nevada's decision regarding a Member's claim.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions.

Approved In-Network Provider

Please see the "Cellular and Gene Therapy Services" benefit in the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge, unless your claim is a Surprise Billing Claim. Please see the "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Behavioral Health and Wellness Practitioner

A person who is licensed to practice Behavioral Health Promotion and Prevention.

Behavioral Health Promotion and Prevention

Supervised clinical use of prevention and intervention strategies relating to mental and behavioral health.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Maximum

The number of days or units of service, such as two office visits per your Benefit Period, for which a health coverage will provide benefits during a specified length of time.

Biomarker Testing

The analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Birth Abnormality

A condition that is recognizable at birth, such as a fractured arm.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer and is also subject to the terms of the Group Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Medical Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Medical Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Complaint

An expression of dissatisfaction with HMO Nevada's services or the practices of an in-network provider, whether medical or non-medical in nature.

Congenital Defect

A defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if precertification is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination Of Coverage."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Please see "Eligibility and Enrollment – Adding Members" for information regarding a newborn child delivered by a Member who acts as a Gestational Carrier or Surrogate.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

- Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which HMO Nevada determines in its sole discretion to be experimental or investigational. HMO Nevada will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:
 - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
 - Has been determined by the FDA to be contraindicated for the specific use.
 - Is provided as part of a clinical research protocol or clinical trial (except where coverage for such trial is mandated by applicable law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
 - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.
- Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by HMO Nevada. In determining whether a service is experimental or investigational, HMO Nevada will consider the information described in subsection (c) and assess all of the following:
 - Whether the scientific evidence is conclusory concerning the effect of the service on health

outcomes.

- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- The information HMO Nevada considers or evaluates to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all inclusive:
 - Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
 - Evaluations of national medical associations, consensus panels and other technology evaluation bodies
 - Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
 - Documents of an IRB or other similar body performing substantially the same function
 - Consent documentation(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
 - The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
 - Medical records
 - The opinions of consulting providers and other experts in the field
- HMO Nevada has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, or Skilled Nursing Facility as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Gestational Carrier or Surrogate

An adult woman who is not the Intended Parent and enters into a gestational agreement, as defined by applicable law, to bear a child conceived using the gametes of other persons and not her own.

Grievance

A written Complaint about the quality of care, denial of a benefit or service received from a Provider.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, HMO Nevada for this Plan.

Group Contract (or Contract)

The Contract between us, HMO Nevada, and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

- Gives skilled nursing and other services on a visiting basis in your home; and
- Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card (ID Card)

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intended Parent

A person, married or unmarried, who consistent with applicable law manifests the intent to be legally bound as the parent of a child resulting from assisted reproduction.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by the FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maintenance Medications

Please see the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90-day supply of Maintenance Medication.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (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, as described in the “Grievance and External Review Procedures” section, 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 or the same intervention in an alternative setting (“cost effective” does not mean lowest cost). It does mean that as to the diagnosis or treatment of the member’s illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting.
- 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 this Booklet.

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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Use Disorder

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or Substance Use Disorder condition. It includes autism spectrum disorder, as required by applicable law. It includes the following conditions, which under state law are any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association:

- Schizophrenia.
- Schizoaffective disorder.
- Bipolar disorder.
- Major depressive disorders.
- Panic disorder.
- Obsessive-compulsive disorder.

Noninvasive Prenatal Screening

Drawing blood from a Member who is pregnant to perform laboratory analysis on the deoxyribonucleic acid circulating in the maternal blood stream for the purpose of detecting chromosomal abnormalities in the fetus.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

Benefits are not available when you use Out-of-Network Providers, unless they are for Emergency Care, Urgent Care, or for services approved in advance by HMO Nevada as an Authorized Service.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the 'Schedule of Benefits' for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

The P&T process is a two-step process used to make determinations that will help you access quality, low-cost medicines within your Plan. This process first uses an independent P&T committee of pharmacists and physicians that evaluate the clinical evidence of each product under review. During the second step of the process, a committee composed of members with various expertise combines the clinical review with an in-depth analysis of market dynamics, Member impact and financial value to make determinations about the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on HMO Nevada's behalf. HMO Nevada's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. HMO Nevada's PBM, in consultation with HMO Nevada, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD) and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group’s Contract with us.

Prescription Drug (Drug)

A substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

Prescription Order

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician / Provider (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics, gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us. Details on our accreditation requirements can be found at <https://www.anthem.com/provider/individual-commercial/join-our-network>. This includes any Provider that state law says we must cover when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the amount determined by a specified state law; the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Referral

Authorization given to a Member to visit another provider.

Residential Treatment Center / Facility

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Self-Administered Hormonal Contraceptive

A Self-Administered Drug which is a contraceptive that utilizes a hormone, is dispensed by an In-Network Pharmacy (with or without a Prescription Order) according to law, and is approved for use by the United States Food and Drug Administration to prevent pregnancy. The term includes, without limitation, an oral

contraceptive, a vaginal contraceptive ring, a contraceptive patch and any other method of hormonal contraceptive identified by the protocol established by applicable law.

Service Area

The geographic area where this Plan is offered. This Plan is only available in certain areas. The areas in which this Plan is offered are listed on “Schedule of Benefits”.

Sickle Cell Disease and Its Variants

An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable.

Site of Service Provider

Site-of-Service (SOS) Providers are surgical, lab, radiology and diagnostic imaging centers that meet cost and other criteria established by HMO Nevada. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a Hospital's name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered “freestanding” Site-of-Service Providers.
- An outpatient Facility location owned by a Hospital that is contracted with HMO Nevada and meets the criteria to be considered “Site-of-Service” (“SOS”).

These entities provide health care services such as surgery, laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Surprise Billing Claim

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for details.

Therapeutic Equivalent Contraceptive Drug

A Drug used for contraception which contains an identical amount of the same active ingredients, in the same dosage and method of administration, as another drug and which is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as the other drug.

Total Disability (or Totally Disabled)

The continuing inability of the Member, because of injury or illness, to perform substantially the duties related to the Member's employment for which the Member is otherwise qualified.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

End of Booklet

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인입니까? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاًاً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Պուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrueff uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differenter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>