Summary of Benefits for
Anthem Balanced Funding HSA 1
$1500-90% 10/30/50/30%

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

	In-Network (Participating Provider)		Out-of-Network (Non-Participating Provider)	
Annual Deductible Deductibles are per calendar year.	Individual coverage, the insured pays a $1,500 deductible per member's benefit year	Family coverage, the family pays a $3,000 deductible per member's benefit year If you select family membership (2 or more members enrolled), no individual deductible applies and the family deductible must be met before this plan provides benefits to any family member. The family deductible amount is met as follows: (1) When one individual has satisfied the family deductible, that family member and all other family members are eligible for benefits, or (2) When no family member meets the family deductible on their own, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits	Individual coverage, the insured pays a $3,000 deductible per member's benefit year	Family coverage, the family pays a $6,000 deductible per member's benefit year If you select family membership (2 or more members enrolled), no individual deductible applies and the family deductible must be met before this plan provides benefits to any family member. The family deductible amount is met as follows: (1) When one individual has satisfied the family deductible, that family member and all other family members are eligible for benefits, or (2) When no family member meets the family deductible on their own, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits

	In-Network (Participating Provider)		Out-of-Network (Non-Participating Provider)	
Out-of-Pocket Annual Maximum All coinsurance and deductible contributes towards the out-of-pocket annual maximum. Some covered services have a maximum number of days, visits or dollar amounts. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.	Individual: $3,000	Family: $6,000 If you select family membership (2 or more members enrolled), no individual out-of-pocket maximum applies and the family out-of-pocket maximum must be met. The family out-of-pocket maximum amount is met as follows: (1) When one individual has satisfied the family out-of-pocket maximum, each family member has satisfied the family out-of-pocket maximum amount, or (2) When no family member meets the family out-of-pocket annual maximum, but the family members collectively meet the entire family out-of-pocket annual maximum, then each family member has satisfied the family out-of-pocket maximum amount.	Individual: $9,000	Family: $18,000 If you select family membership (2 or more members enrolled), no individual out-of-pocket maximum applies and the family out-of-pocket maximum must be met. The family out-of-pocket maximum amount is met as follows: (1) When one individual has satisfied the family out-of-pocket maximum, each family member has satisfied the family out-of-pocket maximum amount, or (2) When no family member meets the family out-of-pocket annual maximum, but the family members collectively meet the entire family out-of-pocket annual maximum, then each family member has satisfied the family out-of-pocket maximum amount.
Lifetime Maximum Benefit	No lifetime maximum			

Services	In Network (Participating Provider)	Out-of-Network (Non-Participating Provider)	Additional Information
1. **Physician Visits**			
a) Physician office visits and physician consultations	90% coinsurance after deductible	70% coinsurance after deductible	Physician visits include diabetic management and limited family planning services (see benefit booklet for additional details).
b) Services related to physician office visit including but not limited to, allergy testing, allergy injections, or office surgeries	90% coinsurance after deductible	70% coinsurance after deductible	
c) Inpatient physician visits	90% coinsurance after deductible	70% coinsurance after deductible	
2. **Retail Health Clinic**	90% coinsurance after deductible	70% coinsurance after deductible	
3. **Preventive Care** Preventive care services that meet the requirements of federal law including screenings, immunizations and office visits.	No charge	70% coinsurance after deductible	
4. **Diagnostic Services, Laboratory, Pathology, and X-ray**			
a) Laboratory, Pathology, and X-ray	90% coinsurance after deductible	70% coinsurance after deductible	Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
b) MRI/MRA, PET, CT scans, nuclear medicine and other high tech services	90% coinsurance after deductible	70% coinsurance after deductible	
5. **Maternity Care**			
a) Prenatal care	90% coinsurance after deductible	70% coinsurance after deductible	
b) Delivery & inpatient baby care	90% coinsurance after deductible	70% coinsurance after deductible	

Services	In Network (Participating Provider)	Out-of-Network (Non-Participating Provider)	Additional Information
6. **Outpatient Therapies: Physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and spinal manipulations/ acupuncture**			
a) Outpatient physical therapy, occupational therapy, speech therapy and cardiac rehabilitation	90% coinsurance after deductible	70% coinsurance after deductible	Limited to 20 visits each of physical, occupational and speech therapy per member per year. Benefits are paid up to 36 visits for cardiac rehabilitation.
b) Outpatient spinal manipulations and acupuncture	90% coinsurance after deductible	70% coinsurance after deductible	Limited to 12 visits per member per year
7. **Hospital Care/Other Facility Services**			
a) Inpatient	90% coinsurance after deductible	70% coinsurance after deductible	
b) Inpatient - acute rehabilitation therapy	90% coinsurance after deductible	70% coinsurance after deductible	Limited to 30 inpatient days per member per year.
c) Outpatient Surgery	90% coinsurance after deductible	70% coinsurance after deductible	
8. **Emergency Care**	90% coinsurance after deductible	90% coinsurance after deductible	Member cost share responsibility for Out-of-Network services will be the same as In-Network services.
9. **Urgent Care**	90% coinsurance after deductible	70% coinsurance after deductible	
10. **Ambulance Services**			Benefits are paid for medically necessary ground or air ambulance transportation.
a) Ground Services	90% coinsurance after deductible	90% coinsurance after deductible	
b) Air Services	90% coinsurance after deductible	90% coinsurance after deductible	
11. **Mental Health and Substance Abuse Care**			
a) Inpatient	90% coinsurance after deductible	70% coinsurance after deductible	
b) Outpatient	90% coinsurance after deductible	70% coinsurance after deductible	

Services	In Network (Participating Provider)	Out-of-Network (Non-Participating Provider)	Additional Information
12. **Medical Supplies and Equipment**	90% coinsurance after deductible	70% coinsurance after deductible	Includes diabetic supplies and equipment, medical supplies, durable medical equipment, oxygen and equipment, orthopedic appliances, prosthetic devices and other appliances. Wigs for alopecia resulting from chemotherapy and radiation therapy are limited to a maximum benefit of $500 per member per year.
13. **Home Health Care**	90% coinsurance after deductible	70% coinsurance after deductible	Limited to 100 visits per member per year.
14. **Chemotherapy, Hemodialysis, and Radiation Therapy**			
a) Inpatient	90% coinsurance after deductible	70% coinsurance after deductible	
b) Outpatient	90% coinsurance after deductible	70% coinsurance after deductible	
15. **Skilled Nursing Facility**	90% coinsurance after deductible	70% coinsurance after deductible	Limited to 100 inpatient days per member per year.
16. **Hospice Care**	90% coinsurance after deductible	70% coinsurance after deductible	
17. **Human Organ and Tissue Transplants**			See the benefit booklet for details on covered transplants.
a) Inpatient	90% coinsurance after deductible	70% coinsurance after deductible	Transportation and lodging services are limited to a maximum benefit of $10,000 per transplant; unrelated donor searches are limited to a maximum benefit of $30,000 per transplant.
b) Outpatient	90% coinsurance after deductible	70% coinsurance after deductible	
18. **Enteral Formula and Special Foods**	90% coinsurance after deductible	70% coinsurance after deductible	Special food products that are prescribed or ordered by a physician as medically necessary is allowed.

Services		Additional Information
19. **Prescription Drugs**		
a) Outpatient Retail Pharmacy Drugs	After deductible is satisfied you pay a tier 1 $10 copayment per prescription, tier 2 $30 copayment per prescription, tier 3 $50 copayment per prescription, tier 4 30% copayment per prescription when received from a contracted pharmacy or 30% copayment after deductible when received from a non-contracted pharmacy	Available up to a 30-day supply.
b) Mail Order Pharmacy Drugs	After deductible is satisfied you pay a tier 1 $10 copayment per prescription, tier 2 $60 copayment per prescription, tier 3 $100 copayment per prescription, tier 4 30% copayment per prescription for a 90-day supply.	Available only through a contracted Pharmacy Benefits Manager (PBM) mail order service up to a 90-day supply. Not available at a non-contracted PBM.
c) Specialty Pharmacy Drugs	After deductible is satisfied you pay a tier 1 $10 copayment per prescription, tier 2 $30 copayment per prescription, tier 3 $50 copayment per prescription, tier 4 30% copayment per prescription. Specialty pharmacy drugs are not available via mail order. The following applies to a), b) and c) above: For the tier 4 outpatient retail pharmacy drugs or specialty pharmacy drugs, the maximum member copayment per prescription is $250 per 30-day supply at a contracted pharmacy or a maximum member copayment per prescription of $500 per 90-day supply for mail order. Prescription drugs will always be dispensed as ordered by your provider and by applicable state pharmacy regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. This plan reserves the right, at our discretion, to remove certain higher cost generic drugs. For drugs on our approved list, call customer service at (866) 837-4596.	Available up to a 30-day supply. Specialty pharmacy drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. They are often unavailable at an outpatient retail pharmacy or mail order pharmacy since these drugs may require special handling such as temperature controlled packaging and overnight delivery. These specialty pharmacy drugs are available only on an in-network basis from the PBM. Specialty pharmacy drugs are not available at non-contracted pharmacies.

Benefit Summary Disclosure Information

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

Coverage for treatment as part of a clinical trial:

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

Coverage for medical treatment is limited to:

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

Coverage for the management and treatment of diabetes

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

Coverage for self-management of diabetes, including:

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

Medically Necessary

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

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

Maximum allowed amount

Reimbursement for services rendered by participating and non-participating providers is based on this health benefits plan maximum allowed amount for the covered service that the member receives.

NOTE: This plan 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 a participating provider in the following circumstances:

- Emergency care (where rendered either within or outside the State of Nevada)
- Where in-patient hospital care at a non-participating hospital is necessary due to the nature of the treatment
- Where in-patient hospital care at a non-participating hospital is necessary due to participating provider hospital capacity
- When a member has received a preauthorized network exception

Emergency

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

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

Maximum Benefits

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

Limitations and Exclusions

This plan does not cover some services. The plan includes limitations and exclusions to protect against duplicate or unnecessary services that could unfairly offset the cost of health care coverage for the entire plan. **Following are examples of the plan's limitations and exclusions** (please consult your benefit booklet for an exhaustive listing of exclusions and limitations)**:**

- Benefits provided under any local, state, or federal laws, including Workers' Compensation and Medicare
- Cosmetic surgery
- Services by a family member
- Weight-reduction services and medications
- Complications from non-covered services
- Our payment allowance will be reduced or denied from what would have been paid if pre-certification is not obtained prior to receiving inpatient hospital services and outpatient surgeries.
- Most services, such as non-emergency hospital admissions or surgical procedures require prior authorization.
- Alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), clonics or iridology.
- Artificial conception
- Services received before the effective date of coverage.
- Biofeedback.

- Chelating agents except for providing treatment for heavy metal poisoning.
- Services or supplies provided as part of clinical research, except where required by law or allowed by Anthem.
- Convalescent care
- Convenience, luxury, deluxe services or equipment. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).
- Court ordered services unless those services are otherwise covered under the certificate.
- Custodial care.
- Dental services, including accident related dental services, dental anesthesia for children, temporomandibular joint therapy or surgery.
- Inpatient care received after the date Anthem, using managed care guidelines, determines discharge is appropriate.
- Hospital care if the member leaves a hospital against the medical advice of the physician, charges which are a direct result of the member's knowing and voluntary non-compliance of medically necessary care with prescribed medical treatment are not eligible for coverage.
- Domiciliary care such as care provided in residential, non-treatment institution, halfway house or school.
- Services and supplies already covered by other valid coverage.
- Experimental/Investigative procedures.
- Genetic counseling.
- Government operated facility such as a military medical facility or veterans administration facility unless authorized by Anthem.
- Hair loss, drugs, wigs, hairpieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a physician prescription, and a medical reason for the hair loss.
- Hearing aids or routine hearing tests.
- Hypnosis, whether for medical or anesthesia purposes.
- This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony which they are convicted of.
- Therapies for learning deficiencies and/or behavioral problems.
- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to keep a scheduled appointment.
- Neuropsychiatric testing.
- Non-covered providers who include but are not limited to:
    - Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
    - School infirmary.
    - Halfway house.
    - Massage therapist.
    - Nursing home.

- Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

- Non-medical expenses, including but not limited to:
  - Adoption expenses.
  - Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this benefit booklet.
  - Vocational training services and supplies.
  - Mailing and/or shipping and handling expenses.
  - Interest expenses and delinquent payment fees.
  - Modifications to home, vehicle, or workplace regardless of medical condition or disability.
  - Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
  - Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
  - Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
  - Voice synthesizers or other communication devices, except as specifically allowed by Anthem's medical policy.
- Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital imperfection or acquired characteristic.
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use. These include but are not limited to, home pregnancy tests and home HIV tests.
- Benefits are not provided for care received after coverage is terminated.
- Private duty nursing services.
- Private rooms are not covered.
- Charges for services and supplies when the member has received a professional or courtesy discount from a provider or where the member's portion of the payment is waived due or professional courtesy or discount.
- Peripheral bone density testing. This coverage does not cover whole body CT scan or routine screening except as described by medical policy or as provided in the benefit booklet.
- Charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.
- Services or supplies necessitated by injuries which a member intentionally self-inflicted, except where the law prohibits such an exclusion.
- Services or supplies related to sex change operations, reversals of such procedures, complications of such procedures, services, supplies or medications related to a sex change operation.
- Treatment of sexual dysfunction or impotence including all services, supplies or prescription drugs used for the treatment.
- Services and supplies which may be reimbursed by a third party
- Travel or lodging expenses for the member, member's family or the physician except as travel or lodging expenses related to human organ and tissue transplants.
- Routine eye examinations, routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which requires the use of contact lenses), or prescriptions for such services and supplies. Surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.

- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.
- Acupuncture except for pain management and chiropractic services except for spinal manipulation. Limited to a combined maximum of 12 visits per calendar year.
- Whole blood, blood plasma and blood derivatives received from community sources or replaced through donor credit.
- Bariatric surgery services.
- Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
- Treatment for autism spectrum disorder.
- Hospice care is covered, but supportive care and services to the family after the death of the patient are not covered.
- Off-label use of FDA-approved prescription drugs.

Rate determinations

Rates are calculated based on allowable case characteristics of member age, geographic rating area, dependent enrollment, and tobacco use.

Provider Directories

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

Provider Network

Under this plan, members choose physicians, hospitals and other health care providers from the Anthem preferred provider organization (PPO) network. Using the PPO network can mean substantial savings. If care is received outside the PPO network, the member will pay a higher deductible and coinsurance and charges over the Maximum Allowed Amount.