CERTIFICATE

Anthem Bronze X 8200 ($0 Preferred Virtual PCP $0 Select Drugs + Incentives)



HMO Nevada

P.O. Box 17549
Denver, CO 80217-7549

RIGHT TO EXAMINE

If this Certificate is provided to You as a new Subscriber, then You shall have the right to read the Certificate and any amendments. If the Subscriber is not satisfied for any reason, the Subscriber may notify Us in writing within 10 days of the Effective Date to terminate the insurance coverage. We will refund to the Subscriber all Premiums paid for that 10 day period unless benefits have been paid, in which case We will use the Premium payments to offset benefit payments. We also reserve the right to recover any benefit payments We have made for claims during that 10 day period.

Thank You for selecting HMO Nevada for Your healthcare coverage. We wish You good health.

DIVISION OF INSURANCE INQUIRIES

For inquiries about healthcare 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 healthcare coverage in Nevada, the Division of Insurance is not equipped to resolve Member Services related inquiries. Please continue to refer these types of inquiries to HMO Nevada Member Services department at 855-330-1217. The Member Services phone number is listed on the Subscriber's Identification Card.

IMPORTANT NOTICE REGARDING PEDIATRIC DENTAL SERVICES

This Certificate does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact Your insurance carrier or Your producer, or seek assistance through www.nevadahealthlink.com, if You wish to purchase pediatric dental coverage or a standalone dental services product.

Anthem Blue Cross and Blue Shield is the trade name of Community Care Health Plan of Nevada, Inc. and Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Welcome to HMO Nevada!

We are pleased that You have become a Member of Our health Plan, where it's Our mission to improve the health of the people We serve. We have designed this Certificate to give a clear description of Your benefits, as well as Our rules and procedures.

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

This Certificate, the application, and any amendments or riders attached shall constitute the entire Certificate under which Covered Services and supplies are provided by Us.

Many words used in the Certificate have special meanings (e.g., 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 Certificate You will also see references to "We," "Us," "Our," "You," and "Your." The words "We," "Us," and "Our" mean HMO Nevada 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!



Mike Murphy
President and General Manager
HMO Nevada

How to Obtain 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. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the Member Services number.)

Contact Us

Member Services is available to explain policies and procedures, and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write HMO Nevada.

The telephone number for Member Services is printed on the Member's Identification Card. The address is:

HMO Nevada
Member Services
P.O. Box 60007
Los Angeles, CA 90060

Visit Us online
www.anthem.com

Hours of operation
Monday - Friday
8:00 a.m. to 6:00 p.m. Mountain Time

Acceptance of coverage under this Certificate constitutes acceptance of its terms, conditions, limitations and exclusions. Members are bound by all of the terms of this Certificate.

Health benefit coverage is defined in the following documents:

This Certificate, the Schedule of Cost Share and Benefits, and any amendments or endorsements thereto

- The Nevada Individual Enrollment Application for the Subscriber and the Subscriber's Dependents
- Identification Card

We, or anyone acting on Our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this Certificate. In the event of any question as to the interpretation of any provision of this Certificate, Our determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or, in the case of surgery, cosmetic. However, a Member may utilize all applicable Complaint, Grievance and Appeal procedures available under this Certificate.

This Certificate is not a Medicare Supplement policy. If You as a Member are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Our Member Services. Contact Our Member Service department for assistance on how to obtain this information.

Conformity with Law

Conformity with State Statutes: Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the State in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Acknowledgement of Understanding

The Subscriber hereby expressly acknowledges their understanding that this Certificate constitutes a contract solely between Subscriber and HMO Nevada, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting HMO Nevada to use the Blue Cross and/or Blue Shield Service Mark in the State of Nevada, and that HMO Nevada is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this Certificate 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 Subscriber for any of HMO Nevada's obligations to the Subscriber created under this Certificate. This paragraph shall not create any additional obligations whatsoever on the part of HMO Nevada other than those obligations created under other provisions of this agreement.

Delivery of Documents

We will provide an Identification Card and a Certificate for each Subscriber.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We 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 (OB/GYN) Care

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in Our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or procedures for making Referrals. For a list of participating healthcare 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.

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, Individual 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 health 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 health plan. Also, the health plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket maximums on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment, Coinsurance and out of pocket maximums applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

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 Services 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 nonemergency 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 claims will not be covered if the Out-of-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for all Out-of-Network charges for those services. This requirement does not apply to Ancillary Services. 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.

How Cost Shares Are Calculated

Your Cost Shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. 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 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 "If You Have a Complaint or an Appeal" section of this Certificate.

Provider Directories

HMO Nevada 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 HMO Nevada that a Provider was In-Network on a particular claim, then You will only be liable for In-Network Cost Share (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network Cost Share will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

HMO Nevada provides the following information on its website at 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 HMO Nevada's website or by calling Member Services at the phone number on the back of Your ID Card:

- Cost Sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing/directory of all In-Network Providers.

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

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

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Anthem Bronze X 8200 ($0 Preferred Virtual PCP $0 Select Drugs + Incentives)

HIOS ID available in rating area 1, 2, 3, 4:

60156NV0440045-01

SCHEDULE OF COST SHARE AND BENEFITS

This chart is an overview of Your benefits for Covered Services, which are listed in detail in the "What is Covered" section. A list of services that are not covered can be found in the "What is Not Covered (Exclusions)" section.

Services will only be Covered Services if rendered by In-Network Providers unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
- The services are approved in advance by HMO Nevada

IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In-Network Provider for this Plan. It is important to understand that HMO Nevada has many contracting Providers who may not be part of the network of Providers that applies to this Plan.

We can help You find an In-Network Provider specific to Your Plan by calling the number on the back of Your Identification Card.

What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Certificate will allow for a Covered Service.

The Deductible applies to all Covered Services with a Copayment and/or Coinsurance, including 0% Coinsurance except for:

- In-Network Preventive Care Services required by law
- Pediatric Vision Service
- Services, listed in the chart below, that specifically indicate that the Deductible does not apply

For a detailed explanation of how Your Deductibles and Out-of-Pocket Limits are calculated, see the "How Your Claims Are Paid" section. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider, You may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

Plan Features

Deductible	In-Network Member Pays	Out-of-Network Member Pays
Individual	$8,200	Not Covered
Family	$16,400	Not Covered
The individual Deductible applies to each covered family Member. No one person can contribute more than the individual Deductible amount. Once two or more covered family Members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Benefit Period.		

Coinsurance	In-Network Member Pays	Out-of-Network Member Pays
Coinsurance Percentage Unless specified otherwise below	40% Coinsurance	Not Covered

Out-of-Pocket Limit	In-Network Member Pays	Out-of-Network Member Pays
Individual	$10,600	Not Covered
Family	$21,200	Not Covered
The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Benefit Period. No one person can contribute more than the individual Out-of-Pocket Limit.		

Medical Services

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Ambulance Services **Emergency**	$0 Copayment 40% Coinsurance	$0 Copayment 40% Coinsurance
Nonemergency If Preauthorized by Us, Out-of-Network nonemergency ambulance services are subject to the same Cost Share as In-Network services up to $50,000 per trip. In addition to Your Cost Share, You will be responsible for amounts over the Maximum Allowed Amount. Air Ambulance services received Out-of-Network are unlimited and not subject to the $50,000 per trip limit	$0 Copayment 40% Coinsurance	Not Covered
Autism Services Professional Services and Outpatient Facility	$0 Copayment 40% Coinsurance	Not Covered
Dental Services See the Dental Related Services provision in the "What is Covered" section for covered dental services	$0 Copayment 40% Coinsurance	Not Covered
Diabetes Services Includes office and Outpatient Facility diabetic education, equipment and supplies	$0 Copayment 40% Coinsurance	Not Covered
Diagnostic Services **Diagnostic Laboratory and Pathology Services** **Office Visit**	Deductible does not apply; $50 Copayment 0% Coinsurance	Not Covered
Outpatient Facility	Deductible does not apply; $50 Copayment 0% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic Imaging Services and Electronic Diagnostic Tests		
Office Visit	Deductible does not apply; $120 Copayment	Not Covered
Outpatient Facility	Deductible does not apply; $120 Copayment	Not Covered
Advanced Imaging Services		
Office Visit	$0 Copayment 50% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 50% Coinsurance	Not Covered
Doctor (Physician) Visits		
Office Visits with PCP: • Primary Care Physician (PCP) • Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic	$0 Copayment 40% Coinsurance	Not Covered
Virtual Visits with PCP	$0 Copayment 40% Coinsurance	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$0 Copayment 40% Coinsurance	Not Covered
Other Office Services	$0 Copayment 40% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Emergency Room Visits Care is covered In-Network and Out-of-Network. For covered Emergency Services from an Out-of-Network Provider, You are not responsible for charges in excess of the Maximum Allowed Amount. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Certificate for more details.	$500 Copayment per Emergency Room Visit 50% Coinsurance	$500 Copayment per Emergency Room Visit 50% Coinsurance
Home Care Services	$0 Copayment 40% Coinsurance	Not Covered
Hospice Care		
Inpatient	$0 Copayment 40% Coinsurance	Not Covered
Outpatient	$0 Copayment 40% Coinsurance	Not Covered
Hospital Services		
Inpatient Facility Inpatient Physical Medicine and Rehabilitation is limited to a maximum of 150 days per Member, per Benefit Period Bariatric Surgery/Gastric Bypass is limited to one surgery every five Years	$0 Copayment 50% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 40% Coinsurance	Not Covered
Inpatient and Outpatient Professional Services	$0 Copayment 40% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Medical Supplies, Durable Medical Equipment and Appliances **Hearing Aids** Limited to a single purchase of a type of hearing aid per ear, including repair and replacement, once every three Years **Prosthetics** Prosthetic devices, their repair, fitting, replacement and components **Enteral Formula and Special Foods** Special food products that are prescribed or ordered by a Physician as Medically Necessary for certain inherited metabolic disorders are allowed Other enteral therapies or nutrition formulas are covered based on the provider rendering the service	$0 Copayment 40% Coinsurance	Not Covered
Mental Health and Substance Use Services		
Inpatient	$0 Copayment 50% Coinsurance	Not Covered
Outpatient	$0 Copayment 40% Coinsurance	Not Covered
Professional Services (includes Mental Health and Substance Use Counseling)	$0 Copayment 40% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Preventive Care Services In-Network services required by law are not subject to Deductible Services include those that meet the requirements of federal and State law including certain screenings, immunizations, all prescribed FDA approved contraceptives and office visits. You can find the current set of preventive benefits at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Skilled Nursing Facility Limited to a maximum of 150 days per Member, per Benefit Period combined with private duty nursing services	$0 Copayment 40% Coinsurance	Not Covered
Surgery **Ambulatory Surgical Center**	$0 Copayment 40% Coinsurance	Not Covered
Therapy Services - Outpatient Includes coverage for Chemotherapy, Occupational, Physical, Radiation, Respiratory and Speech Therapies Inpatient and Outpatient Habilitative and Rehabilitative Therapy Services (limited to 120 visits, per Member per Benefit Period, for Habilitative Therapy Services and a separate but equal number of visits for Rehabilitative Therapy Services). The limits do not apply to Mental Health and Substance Use conditions		
Cardiac Rehabilitation Limited to a maximum of 36 visits per Member, per Benefit Period	$0 Copayment 40% Coinsurance	Not Covered
Occupational Therapy		
Office Visit	$0 Copayment 40% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Facility	$0 Copayment 40% Coinsurance	Not Covered
Physical Therapy		
Office Visit	$0 Copayment 40% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 40% Coinsurance	Not Covered
Speech Therapy Unlimited treatment of stuttering until the Member reaches 26 years of age.		
Office Visit	$0 Copayment 40% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 40% Coinsurance	Not Covered
Chiropractic Care and Spinal Manipulation Therapy Limited to a maximum of 50 visits per Member, per Benefit Period	$0 Copayment 40% Coinsurance	Not Covered
Transplant Human Organ & Bone Marrow/Stem Cell/Cord Blood **Transplant Transportation** In-Network only $10,000 maximum benefit limit per transplant **Lodging** Limited to a maximum of $200 per day **Unrelated Donor Search** Limited to a maximum of the 10 best matched donors per transplant, identified by an authorized registry	Any Covered Services related to a covered transplant procedure are covered under the regular Inpatient and Outpatient benefits.	Not Covered
Urgent Care Center	Deductible does not apply; $75 Copayment per Urgent Care visit 0% Coinsurance	Deductible does not apply; $75 Copayment per Urgent Care visit 0% Coinsurance

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 Providers.

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.

Retail Pharmacy Prescription Drugs (30-day supply per Prescription)	**In-Network Member Pays**		**Out-of-Network Member Pays**
	Level 1 Pharmacy	**Level 2 Pharmacy**	
Oral chemotherapy drugs	Oral chemotherapy drugs are subject to a maximum Copayment or Coinsurance, not to exceed $100 per Prescription and/or refill; day supply limits still apply.		Not Covered
Tier 1	$0 Copayment 40% Coinsurance	$0 Copayment 55% Coinsurance	Not Covered
Tier 2	$0 Copayment 50% Coinsurance	$0 Copayment 65% Coinsurance	Not Covered
Tier 3	$0 Copayment 50% Coinsurance	$0 Copayment 65% Coinsurance	Not Covered
Tier 4	$0 Copayment 50% Coinsurance	$0 Copayment 65% Coinsurance	Not Covered

Notes:

Retail Pharmacy is limited to a 30-day supply per Prescription.

Specialty Drugs must be purchased from the Pharmacy Benefits Manager's Specialty Pharmacy.

The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of $35 per prescription for a 30-day supply when obtained from a Network Retail Pharmacy.

Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

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.

Home Delivery Prescription Drugs	In-Network Member Pays	Out-of-Network Member Pays
Tier 1 (90-day supply)	$0 Copayment 40% Coinsurance	Not Covered
Tier 2 (90-day supply)	$0 Copayment 50% Coinsurance	Not Covered
Tier 3 (90-day supply)	$0 Copayment 50% Coinsurance	Not Covered
Tier 4 (30-day supply)	$0 Copayment 50% Coinsurance	Not Covered

Note:

Specialty Drugs must be purchased from the Pharmacy Benefits Manager's Specialty Pharmacy and are limited to a 30-day supply.

The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of $105 per prescription for a 90-day supply when obtained from a Network Home Delivery Pharmacy.

Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

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.

Pediatric Vision Services

The following vision care services are covered for Members until the end of the month in which they turn 19.

Please see “Pediatric Vision Care” in the “What Is Covered” section for more information on pediatric vision services.

Note: To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Covered vision services are **not** subject to the Calendar Year Deductible.

Covered Vision Services	In-Network Member Pays	Out-of-Network Member Pays
Routine Eye Exam Covered once per Calendar Year per Member.	$0 Copayment	Not Covered
Standard Plastic or Glass Lenses One set of lenses covered per Calendar Year per Member.		
Single Vision	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Progressive	$0 Copayment	Not Covered
Lenticular	$0 Copayment	Not Covered
Additional Lens Options Covered lenses include the following lens options at no additional cost when received In-Network: factory scratch coating, UV coating, standard polycarbonate, standard photochromic, gradient tinting, oversized and glass-grey #3 prescription sunglasses.		
Frames (formulary) One frame covered per Calendar Year per Member.	$0 Copayment	Not Covered
Contact Lenses (formulary) Elective or non-elective contact lenses are covered once per Calendar Year per Member.		
Elective (conventional and disposable)	$0 Copayment	Not Covered
Non-Elective	$0 Copayment	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next Calendar Year.		

Covered Vision Services	In-Network Member Pays	Out-of-Network Member Pays
Low Vision Low vision benefits are only available when received from Blue View Vision Providers.		
Comprehensive Low Vision Exam Covered once per Calendar Year per Member.	$0 Copayment	Not Covered
Optical/Non-Optical Aids and Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per Calendar Year per Member.	$0 Copayment	Not Covered

HOW YOUR COVERAGE WORKS

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Plan. It provides details about In-Network Providers who have entered into an agreement with HMO Nevada and Out-of-Network Providers who have not. You will also find information about how to access a list of In-Network Providers in Your Service Area and the importance of choosing a Primary Care Physician.

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

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 Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

In-Network Services

If Your care is rendered by a Primary Care Physician (PCP), Specialty Care Physician (SCP), or another In-Network Provider, benefits will be paid at the In-Network level. Regardless of Medical Necessity, no benefits will be paid for care that is not a Covered Service even if performed by a PCP, SCP, or another In-Network Provider. All medical care must be under the direction of doctors. We have final authority to determine the Medical Necessity of the service.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Certificate.

- In-Network Providers - include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians or gynecologists geriatricians or other In-Network Providers as allowed by Us. The PCP is the doctor who may provide, coordinate, and arrange Your healthcare services. SCPs are In-Network doctors who provide specialty medical services not normally provided by a PCP.

For services rendered by In-Network Providers:

- You will not be required to file any claims for services You obtain directly from In-Network Providers. In-Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance, and/or Copayments. You may be billed by Your In-Network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Certificate.
- When required, prior approval of benefits is the responsibility of the In-Network Provider. See the "Requesting Approval for Benefits" section.

If there is no In-Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an Out-of-Network Provider for that service as an Authorized Service.

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, Covered Services will be covered at the In-Network level.

Out-of-Network Services

Covered Services which are not obtained from a PCP, SCP or another In-Network Provider, or that are not an Authorized Service will be considered an Out-of-Network service and not covered under Your Plan. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

HMO Nevada has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from non-participating or Out-of-Network

Providers could be balance billed by the non-participating/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.

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 or website. Details on how to download the app can be found on Our website, www.anthem.com.
- 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.

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.

Primary Care Physician (PCP)

The Primary Care Physician (PCP) is a doctor who can provide initial care, basic medical services and can be responsible for ongoing patient care. PCPs are usually internal medicine doctors, family practice doctors, general practitioners, obstetricians, gynecologists, or pediatricians. PCPs may provide care in person or virtually. As Your first point of contact, the PCP gives a wide range of healthcare services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.

Selecting a Primary Care Physician (PCP)

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.

You have direct access for Medical Chats and Virtual Visits with Our virtual care-only partners through Our mobile app.

PCPs include family practitioner, pediatrician, internist, obstetricians, gynecologists, qualified certified nurse practitioners or other qualified Primary Care Physicians, as required by law, for services within the scope of their license. 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, contact 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 Member ID number.
- Tell them the reason for Your visit.

When You meet with Your PCP, be sure to have Your Member Identification Card available.

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.

Referrals

We provide more extensive benefits when healthcare services are provided or coordinated by Your Primary Care Physician. You will receive most of Your healthcare services from Your Primary Care Physician. If Your Primary Care Physician determines that You need specialized care, he or she will authorize You to receive healthcare services from another healthcare Provider. A Referral from Your Primary Care Physician is not a guarantee of coverage for those services. The service must also be covered within the terms of this Contract. Thus, regardless of medical necessity, no benefits will be provided for care that is not a Covered Service, even if performed by Your PCP or authorized as a Referral service. You may call a Member Services Representative at the number on Your ID Card to determine if the service is a Covered Service.

If Your Primary Care Physician authorizes a Referral to a Provider, make sure You understand:

- The name of the Provider to whom You are being referred.
- The period of time, the number of visits and services for which care is authorized.
- Who is to make the appointment(s) with that Provider - You or Your Primary Care Physician's office staff.

While most services will require a Referral, some services do not, such as Medical Chats and Virtual Visits with Our virtual care-only partners through Our mobile app or website.

You will need to discuss additional care recommended by the referring Provider with Your Primary Care Physician, if the care exceeds the initial Referral for services. If Your referred Provider recommends You to another Provider, You must contact Your Primary Care Physician prior to any treatment so he or she can determine if that care will be authorized. Only Your Primary Care Physician can authorize care with another Provider. If Your Primary Care Physician authorizes these services, benefits will be provided according to the terms of this Contract. Care that is not authorized by Your Primary Care Physician is not covered, unless otherwise stated in this Certificate. You do not need a Referral from Your Primary Care Physician for Mental Health and Substance Use treatment services. Please refer to the "Requesting Approval for Benefits" section of this Certificate for details on prior authorization.

Note: If Your Primary Care Physician determines You do not need a Referral and You disagree, You have the right to Appeal the decision, as outlined in the "If You Have a Complaint or an Appeal" section of this Certificate.

Referrals to Specialists

Your Primary Care Physician may refer You to a Specialist. Specialists are Providers who practice in specialty areas such as neurology, surgery, and others. With the prior authorization of Your Primary Care Physician, You can obtain care from In-Network Specialists.

You do not need a Referral or approval from Your PCP to see an obstetrician/gynecologist (OB/GYN).

Referral to Non-Network

You may require services that are not available from Providers within the network. Your Primary Care Physician may make a Referral to an Out-of-Network Provider. Referrals to an Out-of-Network Provider must be approved by Us for services to be reimbursed.

Standing Referrals

A Member with a special condition requiring ongoing care from a specialist may receive a standing Referral to a specialist for treatment of the special condition from the Member's PCP. A special condition is a condition or disease that is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time. A standing Referral must be made according to a treatment plan, approved by Our Medical Director in consultation with the Member's PCP.

Continuity of Care

If Your In-Network Provider leaves Our Network for any reason other than termination for cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still receive In-Network benefits. "Active treatment" includes:

1. An ongoing course of treatment for 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;
2. An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits);
3. An ongoing course of treatment for pregnancy through the postpartum period;
4. A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery;
5. An ongoing course of treatment for a health condition, including Prescription Drugs, for which the doctor or healthcare Provider attests that discontinuing care by the current doctor or Provider would worsen Your condition or interfere with anticipated outcomes. An "ongoing course of treatment" includes treatments for Mental Health and Substance Use Disorders; or
6. 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 are receiving treatment for such illness from such Provider or Facility.

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 Appeals process.

Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the Premiums under this Certificate has the right to services or benefits under this Certificate. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or benefits.

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 Your condition is an Emergency, You should be taken to the nearest appropriate medical Facility. In the event of an Emergency call 911 Emergency response system or the 988 suicide and crisis lifeline.
- Your coverage includes benefits for services rendered by Providers other than In-Network Providers when the condition treated is an Emergency, as defined in this Certificate.

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 healthcare 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 for any injuries suffered by You while receiving care from 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.

REQUESTING APPROVAL FOR BENEFITS

Your Certificate includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Certificate. Utilization Review aids in the delivery of cost-effective healthcare 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 part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of 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 approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. As used here, "clinically equivalent" means treatments that for most Members, will give You 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 Service 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:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. 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 or Investigational as those terms are defined in this Certificate.

For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us as soon as possible. For labor/childbirth admissions, 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 concurrent review.

- **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 or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification. 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	Member	The Member has no benefit coverage for an Out-of-Network Provider unless: • 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). 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 not to be Medically Necessary.

Provider Network Status	Responsibility to Get Precertification	Comments
BlueCard® Provider	Member **(Except for Inpatient admissions)**	The Member has no benefit coverage for a BlueCard® Provider unless: • The Member gets approval to use a BlueCard® Provider before the service is given; or • The Member requires an Emergency Care admission (see note below). If these are true, then • The Member must get Precertification when required (call Member Services). • 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 not to be Medically Necessary. • **BlueCard® Providers must obtain Precertification for all Inpatient admissions.**
NOTE: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us as soon as possible.		

How Decisions are Made

We will 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 “If You Have a Complaint or an Appeal” 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 Certificate 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 the 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.
Concurrent/continued stay review when hospitalized at the time of the request and no previous authorization exists	24 hours from the receipt of the request, We may request additional information within the first 24 hours and then extend to 72 hours
Urgent concurrent/continued stay 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 concurrent/continued stay review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-urgent concurrent/continued stay review	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

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, case management, and disease management) and/or offer an alternative benefit if, in Our discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to participate in a program 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 We exempt a process, Provider or claim from the standards which otherwise would apply, it does not mean that We will do so in the future, or will do so in the future for any other Provider, claim or Member. We may stop or modify any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your online Provider Directory, online pre-certification list, 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 Review guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

Health Plan Individual Case Management

Our health Plan case management programs (Case Management) help coordinate services for Members with healthcare 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 healthcare needs. This is reached through contact and team work with You and/or Your chosen 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 decisions case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and HMO Nevada. 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 representative in writing.

WHAT IS COVERED

This section describes the Covered Services available under this Certificate. Covered Services are subject to all the terms and conditions listed in this Certificate, including, but not limited to, benefit maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements.

Please read the following sections of this Certificate for more information about the Covered Services described in this section:

- “Schedule of Cost Share and Benefits” – for amounts You need to pay and benefit limits
- “Requesting Approval for Benefits” – for details on selecting Providers and services that require preauthorization
- “What is Not Covered (Exclusions)” – for details on services that are not covered

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 "Hospital Services”; “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 Covered Services can be received in several settings, including a doctor’s office, an Urgent Care Center, an Outpatient Facility or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay.

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered 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, fixed wing, rotary wing or water transportation;
- And one or more of the following are met:

  You are taken:
  1. From Your home, scene of an accident or medical Emergency to a Hospital;
  2. Between Hospitals, including when We require You to move from an Out-of-Network Hospital to an In-Network Hospital; or
  3. Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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 an injury by medical professionals during ambulance service, even if You are not taken to a Facility.

Out-of-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount except for Surprise Billing Claims.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

All scheduled ground ambulance services for nonemergency transports, not including acute Facility to acute Facility transport, must be preauthorized.

Air and Water Ambulance

Air and water ambulance services are subject to Medical Necessity review by Us. We retain the right to select the air ambulance Provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for nonemergency Hospital to Hospital transports must be preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of facilities may include, but are not limited to, burn care, cardiac care, trauma care and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider.

Autism Services

This section describes Covered Services and exclusions 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 provided under this section is subject to the same Cost Sharing provisions as other like medical services or Prescription Drugs are covered by this Certificate. 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 doctor, 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. Benefits for applied behavior analysis treatment are limited to a maximum benefit as listed on the “Schedule of Cost Share and Benefits”.
- 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, state certified behavior interventionist or registered behavior technician.
- 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 Applied Behavior Analysis.
- Licensed behavior analyst – a person who holds current certification 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 doctor 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.

- Registered behavior technician – a person who is certified as a behavior technician or an equivalent by the Behavior Analyst Certification Board, Inc., and provides behavioral therapy under the supervision of a:
    1. Licensed psychologist;
    2. Licensed behavior analyst; or
    3. Licensed assistant behavior analyst.
- 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 doctor, 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 preauthorization and Utilization Review - see the "Requesting Approval For Benefits" section for more information.

Services for autism spectrum disorders are subject to the same general exclusions or limitations as other medical services or Prescription Drugs covered by this Certificate. See the "What Is Not Covered (Exclusions)" section of this Certificate.

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. "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.

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. It also includes a phase II, phase III or phase IV study or clinical trial for the treatment of chronic fatigue syndrome. 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 trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare and Medicaid Services.
    e) 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.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) 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 peer review requirement shall not be applicable to cancer clinical trials provided by i-iii below.

i. The Department of Veterans Affairs.
ii. The Department of Defense.
iii. The Department of Energy.

2. Studies or investigations done as part of an Investigational new drug application reviewed by the Food and Drug Administration (FDA);
3. Studies or investigations done for drug trials which are exempt from the Investigational new drug application.
4. 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.

Your Plan may require You to use an In-Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and drugs provided to You in connection with an approved clinical trial and that would otherwise be covered by this Plan.

All requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to Our Clinical Coverage Guidelines, related policies and procedures.

Dental Related Services

This section describes Covered Services for accident related dental services, anesthesia for children, Inpatient services for dental related services, and temporomandibular joint care. **This "dental related services" section provides coverage for health conditions and should not be considered as the Member's dental coverage.** All dental services and supplies are subject to preauthorization guidelines. See the section "Requesting Approval For Benefits" for information on preauthorization guidelines.

Dental Anesthesia

Anesthesia is the loss of normal sensation or feeling. There are two types of anesthesia:

- general anesthesia, also known as total body anesthesia, causes the patient to become unconscious or "put to sleep" for a period of time; or
- local anesthesia causes loss of feeling or numbness in a specific area and is usually injected with a local anesthetic drug such as Lidocaine.

Benefits are provided for general anesthesia when provided in a Hospital, Outpatient surgical Facility or other Facility, and for associated home health services or Facility charges for dental care is provided to a covered Dependent child who:

- has a physical, mental or medically compromising condition;
- has dental needs for which local anesthesia is not effective because of acute infection, an anatomic anomaly or allergy;
- is extremely uncooperative, unmanageable, or anxious; or
- has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Dental Service Related to an Accident

Benefits are provided for accident-related dental expenses when the Member meets all of the following criteria:

- Dental services, supplies and appliances are needed because of an accident in which the Member sustained other significant bodily injuries outside the mouth or oral cavity.
- Treatment must be for injuries to Your sound natural teeth.
- Treatment must be necessary to restore Your teeth to the condition they were in immediately before the accident.

- The first dental services must be performed within 90 days after Your accident.
- Related services must be performed within one Year after Your accident. Services after one Year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances We determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

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 a bleeding disorder or heart condition that make the hospitalization Medically Necessary.

Other Dental Conditions

Benefits are provided in connection with conditions of the mouth (excluding teeth and gums) arising from disease, trauma, injury, or Congenital Defect, if determined to be Medically Necessary.

Diabetic Management

Benefits are provided to Members who have insulin dependent diabetes, non-insulin dependent diabetes and elevated blood 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, glucose monitor and diabetic eye exams. Training and education are covered throughout the Member's disease course when provided by a certified, registered, or licensed healthcare 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 benefits for Prescription Drugs. Please refer to Your "Schedule of Cost Share and Benefits" for Cost Sharing information. Screenings for gestational diabetes are covered under "Preventive Care Services".

Diabetic Management Exclusions

Diabetic supplies and equipment are not covered when received from an Out-of-Network Provider.

Diagnostic Services Outpatient

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

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.

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.

Doctor (Physician) Visits

Covered Services include:

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

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

- **Medical Chats** Covered Services accessed through Our mobile app with a doctor via a text message or chat for limited medical care.
- "**Telemedicine / Telehealth**" means the delivery of healthcare or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing; or secure instant messaging through Our mobile app or website; 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 healthcare 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.

If You have any questions about this coverage, please contact Member Services at the number on the

back of Your Identification Card.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that doctor visits in the home are different than the "Home Care Services" benefit described later in this section.

Retail Health Clinic Care for limited basic healthcare services to Members on a "walk-in" basis. These clinics are normally found in major Pharmacies or retail stores. Healthcare services are typically given by physician 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.

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Specialist e-Consultations are electronic communications between Your PCP, who is rendering care to You, and an In-Network Specialist to help evaluate Your condition or diagnosis. The consultation will be at no cost to You. Your PCP may consider the information provided by the In-Network Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies and the results may be documented in an electronic health record.

Emergency Care Services

If You are experiencing an Emergency please call 911 Emergency response system or 988 suicide and crisis lifeline or visit the nearest Hospital for treatment.

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

Benefits are available in a Facility or independent freestanding Emergency department for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

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.

Emergency Care means a medical or behavioral health exam within the capability of the Emergency department of a Hospital, or independent freestanding Emergency department, and includes ancillary services routinely available in the Emergency department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Stabilize, with respect to an Emergency Medical Condition, regardless of the department of the Hospital in which such further examination or treatment is furnished, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material

deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your doctor calls Us as soon as possible. We will review Your care to decide if a Hospital stay is needed and how many days You should stay. If You or Your doctor does not call Us, You may have to pay for services that are determined to be not Medically Necessary.

Gender Affirming Services

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

Habilitative Services are healthcare services and devices that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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.

Home Care Services

Benefits are available for Covered Services performed by a Home Healthcare Agency or other 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:

- Visits by a licensed healthcare professional, including nursing services by an R.N. or L.P.N., a therapist, or home health aide.
- Infusion therapy; refer to “Therapy Services Outpatient”, later in this section for more information.
- 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 Healthcare 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 Healthcare Provider.
- Medical supplies.
- Durable Medical Equipment.
- Therapy services.

Benefits may also be available for Inpatient Hospital Care in Your home. These benefits are separate from the Home Care Services benefit and are described in the "Inpatient Hospital Care" section below.

Preauthorization is required for home care services.

Hospice Care

Hospice care is a coordinated plan of home, Inpatient and/or Outpatient care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients.

Covered Services and supplies are those listed below if part of an approved treatment plan and when rendered by a hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness.

- Care rendered by an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Facility care when required in periods of crisis or as respite care. Limits apply to respite services (combined maximum benefit of five Inpatient days or five Outpatient visits per Member per 90 days of home hospice care) and to bereavement services (maximum benefit of five group therapy sessions).
- Skilled nursing services and home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member’s death.
- Bereavement services are available to surviving covered family Members.
- Bereavement support services for the covered family Members during the 12 month period

following the death of the Member.

In order to receive hospice benefits (1) Your doctor and the hospice medical director must certify that You are terminally ill and have approximately 12 months or less to live, and (2) Your doctor must consent to Your care by the hospice and must be consulted in the development of Your treatment plan. You may access hospice care while also 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 hospice must maintain a written treatment plan on file and furnish to Us upon request.

Additional Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in hospice and are detailed in other sections of this Certificate.

Hospital Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary 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.
- 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.

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 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 Cost Share and Benefits" under "Hospital Services" will apply.

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.
- Private duty nursing, when provided by a Hospital, ambulatory surgical Facility, Skilled Nursing Facility or hospice care Facility Provider, to the extent required by law.

Outpatient Hospital Care

Your Certificate includes Covered Services in an:
- Outpatient Hospital,
- Freestanding ambulatory surgical center,
- Mental Health and Substance Use Facility,
- Other Facilities approved by Us.

Benefits include Facility and related (ancillary) charges, when Medically Necessary, 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.

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. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:
- Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;
- 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;
- 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.

Note: Under federal law, We may not limit benefits for any Hospital length of stay for childbirth for the mother, or 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 patient's attending Provider, after consulting with the mother or postpartum individual, from discharging the mother or 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.

Please see “Continuity of Care” in the “How Your Coverage Works” section regarding a request to continue to see the same Provider for services.

Contraceptive Benefits

Benefits include up to a three month initial supply, and up to a nine month supply the second time the

drug is dispensed (for up to the remainder of the Benefit Year). In subsequent Benefit Years under this Certificate, 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 Certificate.

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, intra uterine 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 Policy. Benefits also include education and counseling relating to the initiation of use of contraception and any necessary follow-up after initiating such use, including management of side effects relating to contraception. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for further details.

Abortion Services

Benefits for abortions in the case of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

Infertility

Infertility benefits include the following Covered Services:

Limited diagnostic and therapeutic infertility services determined to be Medically Necessary and preauthorized by Us. Covered Services do not include those services specifically excluded herein, but do include limited:

- Laboratory studies.
- Diagnostic procedures; and
- Artificial insemination services, up to six cycles per Member per lifetime.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

Your Certificate 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, purchase or rent-to-purchase equipment and devices, and continuous rental equipment and 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, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device.

Oxygen and equipment for its administration are also Covered Services.

Hearing Supplies

Benefits are available for Members who are certified as deaf or hearing impaired by either a doctor or licensed audiologist. Covered Services include:

- Hearing Aids, including bone anchored hearing aids – Any wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing.

Orthotics and Special Footwear

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes, but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.

Covered Services must be ordered by a doctor and 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 Certificate 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;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by applicable law;
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- Restoration prosthesis (composite facial prosthesis).

Medical and Surgical Supplies

Your Certificate 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.

Diabetic Equipment and Supplies

Your Certificate includes coverage for diabetic equipment and supplies (insulin pump, glucose monitor, lancets and test strips, etc.).

Blood and Blood Products

Your Certificate also includes coverage for the administration of blood products.

Food and Nutrition

This section describes Covered Services and exclusions for 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 Agency must provide the nutrition services. All services must be preauthorized, see the “Requesting Approval for Benefits” section for information on preauthorization guidelines.

Enteral Therapy and Total Parenteral Nutrition

Enteral therapy is 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 under the home health benefits when Medically

Necessary and is not considered Custodial Care. These services are frequently provided through a Home Health Agency. More information can be found under the heading “Home Care Services” and “Hospice Care”.

Benefits are provided for use at home for enteral formulas that are prescribed or ordered by a doctor for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from Congenital Defect 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 doctor as Medically Necessary are allowed. Coverage is provided whether or not the condition existed when coverage began under this Certificate.

TPN received in the home is a covered benefit when it is determined to be Medically Necessary.

Mental Health and Substance Use Services

Benefits are available for the diagnosis, crisis intervention and treatment of acute mental disorders and substance use conditions. Mental Health and Substance Use is 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 condition. For the purposes of this section the Commission on Accreditation of Rehabilitation Facilities is abbreviated as CARF.

Covered Services include the following:

- Inpatient services in a Joint Commission accredited Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Outpatient Services including in-home and office visits and treatment in an Outpatient department of a Hospital or Joint Commission or CARF-accredited Outpatient Facility, such as Partial Hospitalization Programs and Intensive Outpatient Programs.
- Virtual Visits as described under “Doctor (Physician) Visits” subsection.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by The Joint Commission or CARF. It offers individualized and intensive treatment and includes:
    - Observation and assessment by a psychiatrist weekly or more often.
    - Rehabilitation and therapy.
- All drugs approved by the United States Food and Drug Administration to provide medication assisted treatment for opioid use disorder.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- 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.) or
- Any agency licensed by the State to give these services, when We have to cover them by law, or
- A Behavioral Health and Wellness Practitioner licensed to practice Behavioral Health Promotion and Prevention.

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.

Physical Medicine and Rehabilitation Services

Physical medicine and Rehabilitation Services are a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient’s ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or Psychologist.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Preventive Care Services

Preventive care services include 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 Outpatient" 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 law. Examples include screenings for:
    - Breast cancer including a mammogram annually for You if You are 40 years of age or older (see "Diagnostic Services Outpatient" for additional breast cancer diagnostic services),
    - Cervical cancer,
    - High blood pressure,
    - Type 2 diabetes mellitus,
    - Cholesterol,
    - Child or adult obesity,
    - Colorectal cancer,
    - Lung cancer.
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:
    - Contraceptive coverage includes generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives, spermicides, sponges and patches. Contraceptive devices such as diaphragms, contraceptive rings, cervical caps, intra uterine 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 a $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 necessary because a Generic therapeutic equivalent drug is not appropriate for You, You may obtain coverage of the Brand Drug with a $0 Cost Sharing if Your Provider submits an exception request to receive prior approval. Your doctor must complete a contraceptive exception form and return it to Us. You or Your doctor can find the form online at www.anthem.com 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. Brand Drugs will be covered, as preventive care benefits when Medically Necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail, Home Delivery or Specialty Pharmacy".
    - 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 per Calendar Year or as required by law.
    - Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a Provider of healthcare.

- Additional women's preventive care services include well-woman visits which includes at least one visit per Calendar Year beginning at 14 years of age, HPV testing and vaccination, counseling for sexually transmitted infections, and counseling and screening for HIV.
- Behavioral counseling concerning sexually transmitted diseases from a Provider of healthcare for sexually active women who are at increased risk for such diseases;
- Unrestricted coverage of condoms for Members who are 13 years if age or older;
- 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.
- Screening for depression.
- 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.

5. 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 Our Prescription Drug List (a formulary developed by Us).

6. Preventive care services for 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 Pharmacy.
    - Nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
    - Prescription Drugs and OTC items are limited to a no more than 180 day supply per 365 days.
    - Not more than two cessation attempts per Calendar Year and four counseling sessions per Calendar Year.
7. 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

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

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/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Rehabilitative Services

Rehabilitative Services are healthcare services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

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.

Sterilization Services

Benefits for men and women include sterilization services. Reversals of sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" benefit.

Surgery

Your Certificate covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an ambulatory surgical center. 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

Although this Certificate 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;
- 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 congenital 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. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Certificate.

Note: This section does not apply to orthognathic surgery.

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.

Bariatric Surgery

Bariatric surgery and complications from bariatric surgery that satisfy Our medical policy are covered.

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 (braces), repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services Outpatient

Physical Medicine Therapy Services

Your Certificate 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. It does not include massage therapy services at spas or health clubs.
- **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.
- **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.

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 or doctor's office. 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. Also includes total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers Prescription Drugs when they are administered to You as part of a doctor's visit, home care visit, or at an Outpatient Facility. 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.
- **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, administration and treatment planning.

- **Respiratory/Inhalation 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.
- **Chiropractic Services** – Chiropractic benefits are allowed for services administered by a chiropractor who acts within the scope of their license for the chiropractic treatment of an illness or accidental injury. Chiropractic benefits are limited to office visits for manual manipulation of the spine, x-ray of the spine and certain physical modalities and procedures. Please refer to Your "Schedule of Cost Share and Benefits" for visit limits.

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood

This section describes benefits for certain covered transplant procedures that You get during the transplant benefit period. Any Covered Services related to a covered transplant procedure, received before or after the transplant benefit period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Certificate.

Covered Transplant Procedure

Unless applicable law requires greater coverage, a covered transplant procedure is any Medically Necessary human organ and bone marrow/stem cell/cord blood transplants and infusions as determined by Us, including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

The initial evaluation, any added tests to determine Your eligibility as a candidate for a transplant by Your Provider, and the collection and storage of bone marrow/stem cells are included in the covered transplant procedure benefit regardless of the date of service.

Unrelated Donor Searches

Your Plan includes Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Donor search charges are limited to the 10 best matched donors per transplant, identified by an authorized registry.

Live Donor Health Services

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure. If the live donor is not a Member, complications from the donor procedure are covered for up to six weeks from the date of procurement. A live donor is a person who provides the organ, part of an organ or tissue for transplantation while alive to another person.

Transplant Benefit Period

The transplant benefit period starts one day prior to a covered transplant solid organ procedure and one day prior to high dose chemotherapy or preparative regimen for bone marrow stem cell transplants and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the In-Network transplant Provider agreement. Contact the case manager for specific In-Network transplant Provider information for services received at or coordinated

by an In-Network transplant Provider Facility. Services received from an Out-of-Network transplant Facility start on the day of the covered transplant procedure and continue to the date of discharge.

Preauthorization and Precertification

In order to maximize Your benefits, You will need to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network transplant Provider requirements, or exclusions are applicable. Please call Us to find out which Hospitals are In-Network transplant Providers. Contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if We issue 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. Please see the "Requesting Approval for Benefits" section for how to obtain Precertification.

Please note that there are instances where Your Provider requests approval for human leukocyte antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

We will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the Facility where Your transplant evaluation and/or transplant work-up and covered transplant procedure will be performed. Our assistance with travel expenses includes transportation to and from the Facility and lodging for the patient and one companion. Travel costs for the donor are generally not covered, unless We make an exception and approve them in advance of the procedure. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the current version of IRS Publication 502.

The human organ and bone marrow/stem cell/cord blood transplant services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices; and
- Any Covered Services, related to a covered transplant procedure, received prior to or after the transplant benefit period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the mobilization, collection and storage of bone marrow/stem cells is included in the covered transplant procedure benefit regardless of the date of service.

The above services are covered as Inpatient services, Outpatient services or doctor home visits and office services depending where the service is performed and are subject to Member Cost Shares.

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 may include:

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

Prescription Drugs

This section describes how You can obtain covered Prescription Drugs administered by a medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

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 and are Covered Services. This may include drugs for infusion therapy, chemotherapy, hormone replacement therapy, 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 benefit (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, Home Delivery or Specialty 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 Our Prescription Drug List (a formulary developed by HMO Nevada which is a list of 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 "If You Have a Complaint or an Appeal" section of this Contract. 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 "If You Have a Complaint or an Appeal" section of this

Contract. The exception and appeal process is accessible through www.anthem.com. Create an account or log in to existing account then choose Support, then Message Center, then Compose Message, then choose Grievances/Appeals from Subject dropdown box.

Precertification

Precertification may be required for certain Prescription Drugs to 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 “Requesting Approval for Benefits” for more details.

If Precertification is denied, You have the right to file a grievance as outlined in the “If You Have a Complaint or an Appeal” section of this Certificate.

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 Specialty Drugs for treatment of certain clinical conditions such as hemophilia. We reserve Our right to modify the setting and/or level of care in which the care is provided to You. We 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 Your approval 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 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 Pharmacy 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 Pharmacy Member Services at the phone number on the back of Your Identification Card.

Prescription Drug Benefit at a Retail, Home Delivery or Specialty Pharmacy

Your Plan also includes benefits for Prescription Drugs You get at a Retail, Home Delivery or Specialty

Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery 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.

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

Prior authorization is the process of getting benefits approved before certain Prescriptions can be filled.

Prescribing Providers must obtain prior authorization for drug edits 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 "If You Have a Complaint or an Appeal" section of this Contract. 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 "If You Have a Complaint or an Appeal" section of this Contract. The exception and appeal process is accessible through www.anthem.com. Create an account or log in to existing account then choose Support, then Message Center, then Compose

Message, then choose Grievances/Appeals from Subject dropdown box.

You or Your Provider can get the list of the drugs that require prior authorization by calling Pharmacy 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.

We may, from time to time, waive, enhance, change or end certain prior authorization and/or alternate benefits, if in Our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied, You have the right to file a grievance as outlined in the "If You have a Complaint or an Appeal" section of this Certificate.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the 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 Drug Enforcement Administration (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 and supplies and equipment used to administer insulin;
- 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 Services" benefit. Please see that section for more details.
- Flu shots (including administration).
- Hormone replacement therapy.
- Medically Necessary Prescription Drugs for the treatment of Sickle Cell Disease and its Variants to the extent required by law.
- In the event of an Emergency, if You receive Prescription Drugs from an Out of Network Pharmacy, You will not be responsible for amounts in excess of the Maximum Allowed Amount.

Where You Can Get Prescription Drugs

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.

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 "If You have a Complaint or an Appeal" section of this Certificate.

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 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 "If You Have a Complaint or an Appeal" section of this Certificate.

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 Providers.

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.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process. This list will 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 Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem/NVSelectdrugtier4.com.

When You Order Your Prescription Through the PBM's Specialty Pharmacy

You can only have Your Prescription for a Specialty Drug filled through the PBM's Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply per fill. The PBM's Specialty Pharmacy will deliver Your Specialty Drugs to You by mail or common carrier for self-administration in Your home. You cannot pick up Your medication at HMO Nevada.

Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the PBM's Specialty Pharmacy program, We will authorize an override of the Specialty Pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend to allow You to get a 72-hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your Specialty Drug through the PBM's Specialty Pharmacy and it does not arrive, if Your doctor decides that it is Medically Necessary for You to have the drug immediately, We will authorize an override of the Specialty Pharmacy program requirement for a 30-day supply or less to allow You to get an Emergency supply of medication from a Participating Pharmacy near You. A Member Services representative from the PBM's Specialty Pharmacy will coordinate the exception and You will not be

required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain drugs by mail if You take them on a regular basis (Maintenance Medication). 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. Your doctor may also call the Home Delivery Pharmacy.

Maintenance Medication

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, please call Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

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 833-236-6196 or by visiting Our website at www.anthem.com.

When using Home Delivery, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the Home Delivery program, You can call Pharmacy Member Services toll-free at 833-236-6196.

The Prescription must state the dosage and Your name and address; it must be signed by Your doctor.

The first Home Delivery Prescription You submit must include a completed patient profile form. This form will be sent to You upon becoming eligible for this program. Any subsequent Home Delivery Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated Home Delivery Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Home Delivery Prescription Drug program including, but not limited to, antibiotics, drugs not on the Prescription Drug List, injectables, including Self-Administered Injectables except insulin. Please check with the Home Delivery Prescription Drug program Member Services department at 833-236-6196 for availability of the drug or medication.

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.

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.
  Certain low cost drugs, on Tier 1, may be available to Members at no Cost Share. These drugs are listed on Our Prescription Drug List (formulary).
- **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, Biosimilars, Interchangeable Biologic Product 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, Biosimilars,

Interchangeable Biologic Product 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, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

Prescription Drug List

We also have a 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 Prescription 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, and the use of one drug over another by Our Members.

We may add or remove drugs on the Prescription Drug List, or move drugs between tiers, to the extent permitted by applicable law.

If You have a question regarding whether a drug is on the Prescription Drug List, please refer to Our website at www.anthem.com.

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

This Plan limits Prescription Drug coverage to those Prescription Drugs listed on Our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for Our other products. Benefits may not be covered for certain Prescription Drugs if they are not on the Prescription Drug List. Generally, it includes select Generic Drugs with limited Brand Drug coverage. This list is subject to Our periodic review and modification. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. Inclusion of a drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and at www.anthem.com.

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 Prescription Drug 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.

Drug Utilization Review

If there are patterns of over utilization or misuse of drugs, We will notify Your personal doctor and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of drugs.

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 Cost Share and 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 topical ophthalmic products and for synchronizing chronic medications, as required by law. 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, and Topical Opthalmic 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.

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 Pharmacy 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 Pharmacy 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 Pharmacy Member Services number on Your Member ID Card or log on to the Member website at www.anthem.com.

Drug Cost Share Assistance Programs

If You qualify for certain 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 when the Prescription Drug is provided by an In-Network Provider. 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 We may increase the Cost Share listed in the "Schedule of Cost Share and 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 Cost Share and Benefits".

Special Programs

Except where 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. In addition, We may allow access to network rates for drugs not listed on Our Prescription Drug List.

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 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.

Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn 19. To get In-Network benefits, use a Blue View Vision eye care Provider. For help finding one, try "Find a Doctor" on Our website, or call Us at the number on Your ID Card.

See the "Schedule of Cost Share and Benefits" to see Your Deductible, Coinsurance, Copayment and other benefit limitations.

Routine Eye Exam

This Certificate covers a complete routine eye exam with dilation if needed. The exam is used to check all aspects of Your vision.

Eyeglass Lenses

Standard plastic (CR39) or glass eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28), progressive or lenticular.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the "Schedule of Cost Share and Benefits" for the list of covered lens options.

Frames

Your Blue View Vision Provider will have a collection of frames for You to choose from. They can tell You which frames are included at no extra charge - and which ones will cost You more.

Contact Lenses

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options in a given Year. Your Blue View Vision Provider will have a collection of contact lenses for You to choose from. They can tell You which contacts are included at no extra charge - and which ones will cost You more.

Elective contact lenses are ones You choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
- High ametropia exceeding -12D or +9D in spherical equivalent
- Pathological myopia, aphakia, anisometropia (of 3D or more), aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses
- If contact lenses result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Note: We will not pay for non-elective contact lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when You have a significant loss of vision, but not total blindness. Your Plan covers services for this condition when You go to a Blue View Vision eye care Provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

WHAT IS NOT COVERED (EXCLUSIONS)

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.

The following services are not covered:

- Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center or ambulance services related to an Emergency for transportation to a Hospital.

- Services by Out-of-Network Providers unless:
  - the services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
  - the services are approved in advance by Us.

Medical Services

Your Medical benefits do not cover:

Abortions. We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed.

Affiliated Providers. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

After Hours or Holiday Charges. Additional charges beyond the Maximum Allowed Amount for basic and primary services requested after normal Provider service hours or on holidays.

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 Us.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.
- Specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.
- Antigen leukocyte cellular antibody test (ALCAT).
- Cytotoxic test.
- HEMOCODE food tolerance system.
- IgG food sensitivity test.
- Immuno blood print test.

- Leukocyte histamine release test (LHRT).

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bio-energetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Ambulance. Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or doctor is not a Covered Service. Non-Covered Services for ambulance include, but are not limited to, trips to:

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

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific Hospital or doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, doctor's office, or Your home.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.

Autopsies and Post-mortem Testing.

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 Certificate.

Charges Not Supported by Medical Records. Charges for services not described in Your medical records.

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims. However, for covered Emergency Care You receive from an Out-of-Network Provider, the Out-of-Network Provider may be limited in their ability to collect these charges from You.

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- 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; or
- 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; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Cochlear Implants.

Complications of 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.

Complications Resulting from Experimental/Investigative or non Medically Necessary Services or

Treatment. Complications directly related to a service or treatment that is a non-Covered Service under this Certificate because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non-Medically Necessary service.

Compound Drugs. Compound Drugs.

Corrective Eye Surgery. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Cosmetic Services. Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for social reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to, myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

Counseling Services. Counseling services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

Court Ordered Care. For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

Custodial Care. Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Implants. For Dental implants except as specifically stated as a Covered Service in this Certificate.

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Certificate. “Dental treatment” includes, but is not limited to, preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including, but not limited to:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

Dental X-Rays, Supplies and Appliances. For dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified as a Covered Service in this Certificate. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of an immunosuppressive.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

Doctor or Other Practitioners' Charges. Doctor or other practitioners' charges including:

- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending doctor.
- For membership, administrative, or access fees charged by doctors or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

Doctor Stand-by Charges. For stand-by charges of a doctor.

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.

Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or Us.

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.

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 Us.

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).

Durable Medical Equipment. Covered Services do not include Durable Medical Equipment except as specified as a Covered Service in this Certificate. Non-Covered Services or supplies include, but are not limited to:

- Orthopedic shoes or shoe inserts, except as specified as a Covered Service in this Certificate.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training. For 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.

Emergency Care and Urgent Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Follow-up care received in an Emergency department or Urgent Care Center, including, but not limited to, removal of stitches and dressing changes.
- Maternity care and/or deliveries outside the Service Area within five weeks of the anticipated delivery date, except in an Emergency.
- Nonemergency continued care after the Member's condition has stabilized.

Exams - Research Screenings. For examinations relating to research screenings.

Experimental/Investigative. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

Eyeglasses/Contact Lenses. For prescription, fitting, or purchase of eyeglasses or contact lenses except as specified as a Covered Service in this Certificate. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

Family Planning. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

Birth Control.

- Over-the-counter products for birth control purpose (e.g., sponges, spermicides and condoms) except for condoms for Members age 13 and older.
- Reversals of sterilizations.

Infertility.

- Services when the obstruction is related to the reversal of a surgical sterilization.
- Hormonal manipulation and excess hormones to increase production of mature ova for fertilization.
- Any service, supply or drug used in conjunction with or for the purpose of an artificially induced pregnancy including artificial reproductive technology (ART).
- Test tube fertilization, drugs for induced ovulation or other artificial methods of conception.
- Gamete intrafallopian transfer (GIFT) or zygote intrafallopian transfer (ZIFT) and any related services.
- Cost of donor sperm or donor eggs.
- Diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy.
- Storage costs for sperm or frozen embryos.
- Home pregnancy or ovulation tests.
- Sonohysterography.
- Monitoring of ovarian response to stimulants.
- CT or MRI of sella turcica unless elevated prolactin level.
- Evaluation for sterilization reversal.
- Laparoscopy.
- Ovarian wedge resection.
- Removal of fibroids, uterine septae and polyps.
- Open or laparoscopic resection, fulguration, or removal of endometrial implants.
- Surgical lysis of adhesions.
- Surgical tube reconstruction.

Family/Self. Prescribed, ordered or referred by, or received from a member of Your immediate family, including Your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

Feet - Surgical Treatment. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

Food and Nutrition. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Enteral feedings except as specified as a Covered Service in this Certificate
- Tube feeding formula except as specified as a Covered Service in this Certificate
- Food, meals, formulas, and supplements other than those listed, even if the food, meal, formula or supplement is the sole source of nutrition, except as specified as a Covered Service in this

Certificate
- Breast feeding education, see the “What Is Covered” section for coverage of breast feeding support
- Baby formulas
- Feeding clinics

Foot Care – Routine. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including, but not limited to:

- Cleaning and soaking the feet
- Applying skin creams in order to maintain skin tone
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot

Free Care. Free care services You would not have to pay for if You did not 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.

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling, except as specified as a Covered Service in this Certificate, or when Medically Necessary.

Government Coverage. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Gynecomastia. For surgical treatment of gynecomastia.

Hair Loss or Growth Treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

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.

Hospice Care. We do not provide benefits for the following services, supplies or care:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements, except as specified as a Covered Service in this Certificate or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

Human Growth Hormone. Human growth hormone.

Hyperhidrosis. For treatment of hyperhidrosis (excessive sweating).

Impotency. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing. This exclusion shall not apply to services or supplies which are specifically covered in this Certificate, are authorized by Us, or must be covered under applicable law or regulation.

Incarceration. For care required while incarcerated in a federal, State or local penal institution or required while in custody of federal, State or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility Testing and Treatment. Covered Services do not include assisted reproductive technologies (ART) or the diagnostic tests and drugs to support it. Examples of ART include in-vitro fertilization, zygote intrafallopian transfer (ZIFT) or gamete intrafallopian transfer (GIFT).

In-vitro Fertilization (IVF) or Pre-implant Genetic Diagnosis (PGD) of Embryos. Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment.

Maintenance Therapy. For maintenance therapy which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

Medical Chats Not Provided Through Our Mobile App. Texting or chat services provided through a service other than Our mobile app or website.

Medical Equipment, Devices and Supplies. We do not provide benefits for supplies, equipment and appliances 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 that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Missed/Cancelled Appointments. For missed or cancelled appointments.

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.

No Legal Obligation to Pay. For which You have no legal obligation to pay in the absence of this or like coverage.

Non-approved Drugs. Drugs not approved by the FDA.

Non-authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or as specified as a Covered Service in this Certificate.

Non-duplication of Medicare. Benefits are not provided that duplicate any benefits You are entitled to receive under Medicare. If You have questions on how this may apply to You, please call Us.

Nonemergency Care Received in Emergency Room. For care received in an Emergency room that is not Emergency Care, except as specified as a Covered Service in this Certificate. This includes, but is not limited to, suture removal in an Emergency room.

Not Medically Necessary. Any services or supplies which are not Medically Necessary.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as specified as a Covered Service in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either the written Prescription or dispensing by a licensed pharmacist.

Office Visits and Doctor Services. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Expenses for obtaining medical reports or transfer of files.
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata.
- Routine foot care such as care for corns, toenails or calluses except for Members with diabetes.
- Treatment for sexual dysfunction.
- Genetic counseling.
- Separate reimbursement for anesthesia and post-operative care when services are provided by the same doctor in the doctor's office.
- Peripheral Bone Density Scans.

Off Label Use. Off label use, unless We must cover the use by law or if We approve it.

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Orthotic Devices, Shoes or Shoe Inserts. Benefits are not provided for orthotic devices, shoes or shoe inserts except as specified as a Covered Service in this Certificate. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

Outdoor Treatment Camps and/or Programs and/or Wilderness Programs.

Over-the-Counter. For drugs, devices, products, or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug device, product, or supply, except as specified as a Covered Service in this Certificate or as required by law.

Personal Care, Convenience and Mobile/Wearable Devices. For personal hygiene, environmental control, or convenience items including, but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including, but not limited to, daily television rental, telephone services, cots or visitor’s meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch or other personal tracking devices), including any software or applications;
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails);
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

Physical Exams and Immunizations - Other Purposes. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other

purposes.

Private Duty Nursing. For private duty nursing services except as specified as a Covered Service in this Certificate.

Provider Services. Services You get from Providers that are not licensed by law to provide Covered Services, as defined in this Certificate. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Provider Type. Received from an individual or entity that is not a Provider, as defined in this Certificate or recognized by Us.

Reconstructive Services. Reconstructive services except as specified as a Covered Service in this Certificate or as required by law.

Regression Prevention. For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable, except as specified as a Covered Service in this Certificate.

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:

- Domiciliary care provided in a residential institution, treatment center, halfway house or a 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.
- 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.
- 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.

Reversal of Sterilization. For reversal of sterilization.

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as specified as a Covered Service in this Certificate.

Services Not Appropriate for Virtual Visits. Services that We determine require in-person contact and/or equipment that cannot be provided remotely.

Services Not Listed As Covered. Benefits are not provided for any service, procedure, or supply not listed as a Covered Service in this Certificate.

Services, Supplies, or Devices. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us;
- Separate charges for services by professionals employed by a Facility which makes their services available;
- Not listed as covered under this Certificate;
- Not prescribed, performed, or directed by a Provider licensed to do so.

We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Amounts above the Maximum Allowed Amount for a service;

- Neurofeedback and related diagnostic tests;
- The following therapies:
    - group speech therapy; or
    - group or individual exercise classes or personal training sessions.

Shock Wave Treatment. Extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions.

Spinal Decompression Devices. Spinal decompression devices. This includes, but is not limited to, vertebral axial decompression (Vax-D) and DRX9000.

Surrogate Pregnancy. Services or supplies provided to a person not covered under the Certificate in connection with 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.

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as specified as a Covered Service in this Certificate or as required by law.

Teeth, Jawbone, Gums. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or as specified as a Covered Service in this Certificate.

Therapy – Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy
- Recreational therapy
- Sensory integration therapy (SIT)

Therapies - Outpatient. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, behavioral or personality disorders. Therapies (including, but not limited to, speech therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, stuttering, voice or rhythm disorders.
- Benefits are not covered for non-specific diagnoses relating to learning-related disorders.
- Therapeutic exercise equipment prescribed for home use such as treadmills and/or weights.
- Convenience items as determined by Us.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Services related to worker’s compensation injuries.
- Therapies and self-help programs not specifically identified as a Covered Service.
- Recreational, sex, primal scream, sleep and Z therapies.
- Biofeedback.
- Rebirthing therapy.
- Self help, stress management and weight loss programs.
- Transactional analysis, encounter groups and transcendental meditation (TM).
- Sensitivity training, anger management or assertiveness training.
- Rolfing, pilates, Myotherapy (physical diagnosis, treatment and pain management of conditions which cause pain in muscles and bones) or prolotherapy.

- Holistic Medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes are not covered, except as otherwise specifically provided herein.
- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).
- Acupuncture care except as provided herein.

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions. Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care.
- Meals.
- 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.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

Virtual Visits. Virtual Visits do not include the use of facsimile, texting (outside of Our mobile app), electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal laboratory 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 the “What Is Covered” section.

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

Waived Copayment, Coinsurance, or Deductible. For any service for which You are responsible under the terms of this Certificate to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

Weight Loss Programs. For weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as a Covered Service in this Certificate. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Workers’ Compensation. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment, except as specified as a Covered Service in this Certificate.

Prescription Drugs

Your Prescription Drug benefits do not cover:

- Administration Charges for the administration of any drug except for covered immunizations as approved by Us or the PBM.
- An Allergenic Extract or Vaccine.
- Charges Not Supported by Medical Records. Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- 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.
- Compound Drugs. Compound 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.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- 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 specified in "Therapy Services Outpatient", or drugs specified in "Medical Supplies, Durable Medical Equipment and Appliances" in the "What is Covered" section.
- Drugs Not Approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or Us.
- 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.
- 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 HMO Nevada.
- 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. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Drugs Used for Cosmetic Purposes.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors.
- Lost, Damaged, Destroyed or Stolen Drugs. Refills of lost, damaged, destroyed or stolen drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service. Prescription Drugs dispensed by any mail service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- 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.

- Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this Certificate 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.
- Off Label Use. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Onychomycosis Drugs. Drugs for onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items may not be covered. 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. This includes Prescription Drugs when any version or strength becomes available over-the-counter.
- Prescription Drugs Shared by Member. Any Prescription Drug prescribed to a Member that is subsequently shared with other individuals.
- Prescription Drugs used to Treat Infertility.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, domestic partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Sexual Dysfunction Drugs. Drugs to treat sexual or erectile problems.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight Loss Drugs. Any drug mainly used for weight loss.

Pediatric Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for Members age 19 and older, except as specified as a Covered Service in this Certificate.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse or domestic partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified as a Covered Service in this Certificate.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified as a Covered Service in this Certificate.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specified as a Covered Service in this Certificate.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of Our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.

HOW YOUR CLAIMS ARE PAID

This section describes how Your claims are administered, explains the Cost Sharing features of Your Plan, and outlines other important provisions. The specific Cost Sharing features, and the applicable benefit percentages and/or limitations, are outlined in the "Schedule of Cost Share and Benefits" section.

We consider Covered Services to be incurred on the date a service is provided. This is important because You must be actively enrolled on the date the service is provided.

Cost Sharing Requirements

Cost Sharing is how HMO Nevada shares the cost of healthcare services with You. It means what HMO Nevada is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Copayments, Deductibles and/or Coinsurance (as described below).

HMO Nevada works with doctors, Hospitals, Pharmacies and other healthcare Providers to control healthcare costs. As part of this effort, most Providers who contract with HMO Nevada agree to control costs by giving discounts to HMO Nevada. Most other insurers maintain similar arrangements with Providers.

The contracts between HMO Nevada and Our In-Network Providers include a "hold harmless" clause which provides that You cannot be held responsible by the Provider for claims owed by HMO Nevada for healthcare services covered under this Certificate.

Covered Services that are not obtained from a PCP, SCP or another In-Network Provider, or that are not Authorized Services will not be covered. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

Copayment

Copayment means the fixed dollar amount You may be responsible for when You visit a Provider or fill a Prescription for covered Prescription Drugs at the Retail or Home Delivery Pharmacy. In some instances, a Copayment may be required before the Deductible for certain Covered Services. Your Copayment responsibility is shown in Your "Schedule of Cost Share and Benefits." Whether a Copayment applies to a Covered Service, depends on Your Certificate's benefit design.

Copayments do not accumulate towards the Deductible, however Copayments satisfied in a Calendar Year accumulate towards the Out-of-Pocket Limit.

Coinsurance

Coinsurance means the percentage of the Maximum Allowed Amount for which You are responsible for a specified Covered Service. For example, if Your Coinsurance percentage listed on Your "Schedule of Cost Share and Benefits" is 20%, You are responsible for 20% of the Maximum Allowed Amount. See the explanation of Maximum Allowed Amount in this section for additional information. Whether a Coinsurance applies to a Covered Service depends on Your Plan's benefit design.

Deductible

A Deductible is a specified dollar amount for Covered Services that the Member must pay within each Calendar Year before HMO Nevada reimburses You for Covered Services. A Copayment may be required before the Deductible for certain Covered Services. The Deductible amount is listed in the "Schedule of Cost Share and Benefits" section. A new Deductible applies at the beginning of each Calendar Year.

Deductible Calculation

Each family Member's Maximum Allowed Amounts for Covered Services is applied to his or her individual Deductible. Once two or more family Members' Maximum Allowed Amounts for Covered Services combine to equal the family Deductible, then no other individual Deductible needs to be met for that Calendar Year. No one person can contribute more than his or her individual Deductible to the family Deductible.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how Your Plan works, please refer to the "Schedule of Cost Share and Benefits."

The family Deductible is also applicable for newborn and adopted children for the first 31 day period following birth or adoption if the child is enrolled or not enrolled following the 31 day period.

Out-of-Pocket Limit

The Out-of-Pocket Limit for Covered Services is the sum of the Deductible and Copayment/Coinsurance maximums paid in a Calendar Year. "Out-of-Pocket Limit" is the most You pay for Covered Services in a Calendar Year. Once You meet Your Out-of-Pocket Limit, HMO Nevada will cover 100% of the Maximum Allowed Amount for Covered Services for the rest of that Calendar Year.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a Calendar Year apply to the Out-of-Pocket Limit.

The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year. No one person can contribute more than his or her individual Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost Sharing will be required for the remainder of the Calendar Year.

The Family Membership Out-of-Pocket Limit is also applicable for newborn and adopted children for the first 31-day period following birth or adoption whether or not the child is enrolled following the first 31-day period.

Out-of-Pocket Limit Exceptions

Please read this section very carefully. Not all money that You pay toward Your healthcare costs are counted toward Your Out-of-Pocket Limit.

Amounts You incur towards Your Deductible, Copayments and/or Coinsurance count towards the Out-of-Pocket Limit. However, the following will never count towards the Out-of-Pocket Limit, nor will they ever be paid under this Plan:

- Amounts exceeding the Maximum Allowed Amount;
- Amounts over any Plan maximum or limitation; and/or
- Expenses for services not covered under this Certificate.

Benefit Period Maximum

Some Covered Services have a maximum number of days or visits that HMO Nevada will allow during a Benefit Period. When the Deductible is applied to a Covered Service that has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if You have satisfied the applicable Out-of-Pocket Limit. See the "Schedule of Cost Share and Benefits" for those services which have a Benefit Limit. For Example, Cardiac Rehabilitation states "Limited to a maximum of 36 visits per Member, per Benefit Period".

Balance Billing

In-Network Providers are prohibited from balance billing. An In-Network Provider has signed an agreement with HMO Nevada to accept Our determination of the Maximum Allowed Amount or reimbursement rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Certificate, e.g., Deductibles (if any) or Coinsurance. When You receive Covered Services from an Out-of-Network Provider, including in an Emergency or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges unless You receive a Surprise Billing Claim.

Maximum Allowed Amount

General

This provision 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 Your Certificate's Maximum Allowed Amount for the Covered Service that You receive. Please also see "Inter-Plan Programs" provision for additional information.

The Maximum Allowed Amount for this Certificate 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 Certificate and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, Utilization Review, or other requirements set forth in Your Certificate.

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 Certificate are not covered except for Emergency care, or when services have been previously authorized by Us. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider either in an Emergency or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network 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 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 Your Certificate 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 Our website 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 were previously authorized by Us.

Except for Surprise Billing Claims, We will calculate the Maximum Allowed Amount for Covered Services You receive in an Emergency or if previously authorized from an Out-of-Network Provider, using one of the following:

1. An amount based on Our Out-of-Network Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with HMO Nevada, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; 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; or
7. An amount based on the Medicaid fee schedule established by the State. When basing the Maximum Allowed Amount upon the level or method of reimbursement established by the State for Medicaid, We will update such information no less than annually.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered Out-of-Network. For this Certificate, the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between HMO Nevada and that Provider specifies a different amount or if Your claim involves a Surprise Billing Claim.

For services rendered outside HMO Nevada’s Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross and/or 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.

Except when You get covered Emergency Services from an Out-of-Network Provider, Out-of-Network Providers 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. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to You. 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 Your Certificate'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 PBM.

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 will 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 Certificate and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your day/visit limits.

The following are examples for illustrative purposes only; the amounts shown may be different than this Certificate's Cost Share amounts; see Your "Schedule of Cost Share and Benefits" for Your applicable amounts.

Example: Your Certificate has a Coinsurance Cost Share of 20% for In-Network services after Deductible has been met.

You undergo a nonemergency surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from Us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, Your total out-of-pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.
- You choose an In-Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The In-Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket responsibility would be $300.
- You choose an Out-of-Network surgeon. Unless previously authorized by Us, all services will be denied and You will be responsible for the total amount billed.

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 circumstance, You must contact Us in advance of obtaining the Covered Service. If We authorize an In-Network Cost Share amount to apply to a Covered Service received from an Out-of-Network

Provider, You will not be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Certificate's Cost Share amounts; see Your "Schedule of Cost Share and Benefits" for Your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty available to You. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available Out-of-Network Provider for that Covered Service and We agree that the In-Network Cost Share will apply.

Your Certificate has a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the In-Network Cost Share amount to apply in this situation, You will be responsible for the In-Network Copayment of $25 and We will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, You may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your In-Network Copayment of $25, Your total out-of-pocket expense would be $325.

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 ("non-participating 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 Care or Urgent Care services received at an Urgent Care Center 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. Non-participating 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, 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 non-participating Providers. In these situations, You may be liable for the difference between the amount that the non-participating 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 Care, including ambulance and Urgent Care services 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 "Requesting Approval for Benefits" section.

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 www.bcbsglobalcore.com.

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

Notice of Claim and 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. We will send the form to You within 15 days. If You do not receive the claim form within 15 days, You can still submit written notice of the claim without the claim form. 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.

  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.

Payment of Benefits

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper, except for claims for Emergency Care Services or Surprise Bills for Air Ambulance Services or nonemergency Services performed by nonparticipating Providers at certain participating Facilities which will be paid within 30 calendar days of receipt of information necessary to determine claim payment. "Clean claim" means a claim submitted by You or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We fail to pay an approved claim timely, We will owe interest to the Provider.

If We fail to pay or deny a clean claim in 30 days for a claim filed electronically; or in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Nevada law.

We will pay the benefits of this Certificate directly to Out-of-Network Providers, depending on whether You have authorized an assignment of benefits and where required by law. We may require a copy of the assignment of benefits for Our records. If We pay You directly, You are responsible for paying the Provider for all charges. These payments fulfill Our obligation to You for those services.

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.

Claim Denials

If benefits are denied, in whole or in part, HMO Nevada will send the Member a written notice within the established time periods described in the section “Payment of Benefits.” The Member or the Member’s duly authorized representative may Appeal the denial as described in the “If You Have a Complaint or an Appeal” section. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim Appeal procedures and time limits.

If the denial involves a Utilization Review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge;
- That an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

Where to Send Your Claim

Claims sent to any authorized agent of the insurer, with information sufficient to identify the Subscriber, is considered notice to the insurer. You should make copies of the bills for Your own records and attach the original bills to the completed claim form. The bills and the claim form must be mailed to:

HMO Nevada
Attn. Claims Department
P.O. Box 60007
Los Angeles, CA 90060

Right of Recovery and Adjustment

Whenever payment has been made in error, or in excess of the maximum amount of payment necessary to satisfy the provisions of this Plan, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments 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 of 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 may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to Us, Our affiliates, agents or designees will permit Us to deny claims for 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 this Certificate. We reserve the right to make payments directly to You as opposed to any Provider for Covered Service, at Our discretion. 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 Subscriber's Contract), 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.

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 this Certificate are not assignable by any Member without the written consent of HMO Nevada. This prohibition against assignment includes rights to receive payment, claim benefits under this Certificate and/or law, and sue or otherwise begin legal action. Any assignment made without written consent from HMO Nevada will be void and unenforceable.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by Your coverage;
- The amount for which You are responsible (if any);

- General information about Your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Payment Owed to You at Death

Upon the death of a Member, claims will be payable in Our discretion to either the Member's estate or a beneficiary designated to Us. If the Provider is an In-Network Provider, claims payments will be made to the Provider.

Claims Review for Fraud, Waste and Abuse

HMO Nevada has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency Services, Urgent Care services received in an Urgent Care Center or other services authorized by Us in accordance with this Certificate from non-participating/Out-of-Network Providers could be balance billed by the non-participating or 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.

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

Payment Innovation Programs

We pay 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 healthcare 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 a Network Provider’s total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, 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 healthcare. The Program payments are not made as payment for specific covered healthcare services provided to You, but instead, are based on the 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).

IF YOU ARE COVERED BY MORE THAN ONE POLICY

The Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one Plan. Plan is defined below.

Please note that several terms specific to this provision are listed below. For this provision, the terms below will have the meanings, as describe in this section. Some of these terms may have different meanings, in other parts of the Contract. In the rest of the Contract, the meaning of a term can be determined based on the "Definitions" section, provided at the end of this Contract.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Coordination of Benefits Definitions

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by State law; school accident type coverage; medical benefits under group or individual "no-fault" and traditional "fault" type automobile contracts; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have healthcare coverage under more than one Plan.

When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is Secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a healthcare expense, including Deductibles, Coinsurance and Copayments that is covered at least in part by any Plan covering You. 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 person 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 You is not an Allowable Expense.

The Allowable Expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowed Amount.

The following are not Allowable Expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If You are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If You are 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.
5. The amount of any benefit reduction by the Primary Plan because a Member has 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.
6. 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.

Closed Panel Plan is a Plan that provides healthcare benefits primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or Referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

Except as provided in the paragraph below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major

medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is Secondary to that other Plan.

If You receive services from an oral and maxillofacial surgeon that may be covered, in whole or in part, by a stand-alone dental benefit and this policy, the claims should first be submitted to the stand-alone dental policy and this health benefit policy will the secondary policy for such services.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule (1) Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, Member, policyholder, Subscriber or retiree is the Primary Plan and the Plan that covers You as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, Subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

Rule (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

A. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

B. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's healthcare expenses or healthcare coverage, Rule (2)(A) above shall determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent child, Rule (2)(A) above shall determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
        - The Plan covering the custodial parent;
        - The Plan covering the spouse of the custodial parent;
        - The Plan covering the non-custodial parent; and then
        - The Plan covering the spouse of the non-custodial parent.

C. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, Rule (2)(A) or Rule (2)(B) above shall determine the order of benefits as if those individuals were the parents of the child.

Rule (3) Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Rule (1) above can determine the order of benefits.

Rule (4) COBRA or State Continuation Coverage. If You are covered under COBRA or under a right of continuation provided by State or other federal law, the Plan covering You as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Rule (1) above can determine the order of benefits.

Rule (5) Longer or Shorter Length of Coverage. The Plan that covered You as an employee, Member, policyholder, Subscriber or retiree longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule (6) If the preceding rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefit of This Plan

When This Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan Year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

Because the Allowable Expense is generally the higher of the Primary and Secondary Plans' allowable amounts, an In-Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

If You are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

When This Plan is Secondary, You will receive credit during the Calendar Year for the amount by which Your benefits are reduced. This credit will not be applied to the extent that would cause You to receive:

- A combined benefit from all Plans greater than the Allowable Expense; or
- More benefits during a Calendar Year than You would receive if there were no other coverage.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must

give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination with Medicare

Unless federal law requires the Plan to be the primary payor, the benefits under This Plan for Members age 65 and older do not duplicate any benefits Members are entitled to (and automatically enrolled in) under Medicare Part A or enrolled in (and pay their own premiums) under Medicare Parts B, C, and/or D.

IF YOU HAVE A COMPLAINT OR AN APPEAL

This section explains what to do if a Member disagrees 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. Please refer to the "Definitions" section to review defined terms.

Complaints

If the Member has a Complaint about any aspect of Our services or claims processing, the Member should contact Our Member Services department or write Us at:

HMO Nevada
Member Services Department
700 Broadway
Denver, CO 80273

If the Member has questions regarding eligibility or membership, the Member should contact Our Member Services department or write Us at:

HMO Nevada
700 Broadway
Denver, CO 80273

Complaints can be made about many things such as Member services, claims administration, benefit determination, eligibility, quality of care, access to Providers, Network adequacy, etc. Some descriptions are very narrow. A trained representative will work to clear up any confusion and resolve the Member's concerns. If the Member is not satisfied with the resolution, the Member can file an Appeal as explained under the APPEALS heading in this section.

Appeals

The Member must request an internal Appeal within 180 calendar days from the date the Member was notified of Our adverse decision. Appeals may be for Precertification denials or post-service denials. We will assign an employee to assist the Member in the Appeal process. The Member may send written Appeals to the following address:

Grievance and Appeals
700 Broadway
Denver, CO 80273

Blue View Vision Coverage Appeals

Please submit Appeals regarding Your vision coverage to the following address:

Blue View Vision
P.O. Box 9304
Minneapolis, MN 55440-9304

A written Appeal must state plainly the reason(s) why the Member disagrees with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Appeal should include any pertinent documents and medical records not originally submitted with the claim or request for the service or supply and any other information that the Member feels may have a bearing on the decision. Also, please include the following details with Your Appeal if You have them:

- The Member's name, address and phone number;
- The identification number as shown on Your Identification Card (including the 3-letter prefix);
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which You don't agree; and
- Any bills that You have received from the Provider.

Through the Appeal process, the Member can access one level of Appeal, and, where appropriate, independent external review. The Member can designate a representative (e.g., the Member's doctor or anyone else of the Member's choosing) to assist the Member with filing the Appeal. In some instances,

We may ask the Member to designate the Member's representative in writing. The Member or the Member's representative can review the Member's Appeal file on request, and can present evidence as part of the Appeal process.

Report Appeals through healthcare.gov:

https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/

First Level Appeal

First level Appeals will be reviewed by a review board. The members of the board will not have been involved in the original coverage decision. However, a person that was involved in the original coverage decision, or a healthcare professional with appropriate experience, may answer questions relating to the Appeal. Unless the Member agrees to a longer period, We will provide a decision in writing within 30 calendar days after receipt of the Appeal.

Expedited Appeal

A Member or Member's representative has the right to request an expedited Appeal when the timeframes for a standard review could:

- Seriously jeopardize the Member's life or health;
- Jeopardize the Member's ability to regain maximum function; or
- Create an imminent and substantial limitation on the Member's existing ability to live independently if the Member has a disability.

Expedited Appeals will be resolved as quickly as the Member's medical circumstances require, but not later than 72 hours after receipt of the request. To request an expedited Appeal, the Member, the Member's Provider or the Member's representative can contact Member Services at the phone number on the Member's Identification Card, fax the request to 303-764-7294 or send a written request to address above.

Independent External Review Appeal

If Our decision involved making a judgment as to the Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness of the healthcare service or treatment the Member requested, the Member may have the right to independent external review, where Our decision will be reviewed by healthcare professionals who have no association with Us. The Member may also request an independent external review when a claim has been denied based upon a determination that the recommended or requested healthcare service or treatment is Experimental or Investigational treatment. Except as noted below, in order to request an independent external review, the Member must have first completed a first level Appeal But if We fail to respond to a Complaint or Appeal within 30 calendar days, and the Member has not agreed to an extension, the Member can request an independent external review and the Member will be considered to have exhausted the internal Appeals process. Also, in some instances, We may (but is not required to) agree to an independent external review even if the Member has not exhausted the First level Appeal.

The request for Independent External Review must be made to the Nevada Office of the Governor, 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 for Consumer Health Assistance, which can be contacted at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 888-333-1597

- Within five business days after receiving the request for external review, the Office for Consumer Health Assistance shall notify the Member, 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 five 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 five 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 the Member if additional information is needed to conduct the review.
- Additional information must be provided within five days after receiving the request.
- The Independent Review Organization shall forward a copy of the additional information to Us within one business day after receipt.
- Within 15 days of completing the review, the Independent Review Organization shall submit a copy of its determination to the Member.

When the Member or the Member's representative request Independent External Review, the Member 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 the Member's claim is determined to be not eligible for independent external review, the Member will be notified of that decision. However, if the Member's 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 healthcare service for which the Member received Emergency Services but has not been discharged from the Facility providing the services or care; or (2) failure to proceed in an expedited manner may jeopardize the life or health of the Member or the Member's 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, the Member's treating doctor certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated. Typically, a Member 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 doctor certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, and, if the Member has a medical condition where the time to complete an expedited Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function, then the Member or Member's representative can request expedited independent external review at the same time as requesting an expedited Appeal. If eligible for expedited independent external review, the Independent Review Organization assigned to the Member's case will then determine whether the independent external review should be decided before the Member's expedited 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 one 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 the Member and We agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the Independent Review Organization must notify the Member, doctor and Us of its determination by telephone, followed up in writing within 48 hours.

The Member or the Member's 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:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 888-333-1597

When the Member or the Member's representative request independent external review, the Member 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 the Member's claim is determined to be not eligible for independent external review, the Member will be notified of that decision. However, if the Member's 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 the Member to submit to the independent evaluation. The evaluation will be conducted by a doctor, dentist or chiropractor who is certified to practice in the same field of practice as the primary treating doctor, 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 doctor, dentist or chiropractor. A certified copy of all reports of findings must be sent to the primary treating doctor, dentist or chiropractor and the Member within 10 working days after the evaluation. If the Member disagrees with the findings of the evaluation, the Member must submit an Appeal to Us, 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 doctor, 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 doctor, dentist or chiropractor may not recover any payment from Us, the Subscriber or the patient for services that the doctor, dentist or chiropractor provided to the patient after receiving written notice from Us.

Grievances

The Member may send a written Grievance, which is a complaint about the quality of care or service received from a Provider, to the following address within 60 days of the event:

Grievance and Appeals
700 Broadway
Denver, CO 80273

Our Quality Management Department will acknowledge receipt of, and investigate, the Member's 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 no earlier than 60 days after We receive the claim or other request for benefits and within three Years of Our final decision on the claim or other request for benefits. If We decide an Appeal is untimely, Our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust Our internal Appeals process before filing a lawsuit or other legal action of any kind against Us.

Please refer to the section "Prescription Drug List" for the process for submitting and exception request for drugs not on the Prescription Drug List.

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Certificate are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

To be eligible for membership as a Subscriber under this Certificate, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan;
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the State of Nevada and meet the following applicable residency requirements:

   For a Qualified Individual age 21 and over, the applicant must:

   - Not be living in an institution;
   - Be capable of indicating intent;
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area applicable to this Certificate.

   For a Qualified Individual under age 21, the applicant must:

   - Not be living in an institution;
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
   - Not be emancipated;
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area applicable to this Certificate.
6. Agree to pay for the cost of the Premium that We require;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B, C and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, a Qualified Individual's Service Area is the area in which the Qualified Individual:

1. resides, intends to reside (including without a fixed address); or
2. is seeking employment (whether or not currently employed); or
3. has entered with a job commitment.

For Qualified Individuals under age 21, the Service Area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the Members of a tax household are not living within the same Exchange Service Area, any Member of the tax household may enroll in a QHP through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. If both spouses in a tax household enroll in a QHP through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets residency requirements.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1. The Subscriber’s legal spouse.
2. The Subscriber’s domestic partner - domestic partner is a person, other than a spouse, with whom one cohabits. A domestic partner is only eligible for coverage if (a) Nevada law recognizes

the relationship, however named, as a valid domestic partnership, or (b) if the domestic partnership is entered into in Nevada and the Nevada Secretary of State has issued a Certificate of Registered Domestic Partnership and the Subscriber and domestic partner:

- Have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- Desire by their own free will to enter into a domestic partnership.
- Share a common residence on at least a part time basis.
- Are mentally competent, at least 18 years old; unrelated to one another in any way (including by blood or adoption) that would prohibit him or her from being married under State law; and
- Are not married to or separated from anyone else.
    a. For purposes of this Certificate, 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.
    b. A domestic partner's or a domestic partner's child's coverage ends at the end of the month of the date of dissolution of the domestic partnership.
    c. To apply for coverage as domestic partners, both the Subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the Exchange.

3. The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children until age 26. However, this does not include a newborn child conceived or delivered by the Member while acting as a Gestational Carrier or Surrogate.
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian until age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical impairment. The Dependent's impairment must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any Dependent. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Certificate unless required by the laws of this State.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), during the annual open enrollment period or as an enrollee to add a Qualified Individual to the current QHP during a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in or change a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals to enroll in or change a QHP as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, domestic partnership, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move, provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move;
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide; and
- A Qualified Individual newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

We may ask You for documentation or other proof of a Qualifying Event. If, for reasons other than Your own delay or failure to supply Us with needed information, Your application is delayed while We validate a Qualifying Event, You can postpone the start date of Your coverage for up to one month.

If You cannot find Your situation, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in Minimum Essential Coverage at least one day in the 60 days before marriage; or lived abroad for one or more days in the 60 days before marriage; or is an American Indian or Alaskan Native.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth, to the extent required by applicable law. This would also apply to the newly born, eligible child of a covered Dependent child. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Certificate and You must pay HMO Nevada timely for any additional Premium due.

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.

A child will be considered adopted from the earlier of: (1) placement for adoption; or (2) the date the court enters a decree granting the 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.

Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's Certificate and You must pay HMO Nevada timely for any additional Premium due.

Adding a Child due to Award of Court-Appointed Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Certificate must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Court Ordered Health Coverage

If You are required by a court order, as defined by applicable State or federal law, to enroll Your child under this Certificate, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Certificate, and once approved by the Exchange, We will provide the benefits of this Certificate in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent age limit. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid to HMO Nevada.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date. Advance Payments of the Premium Tax Credit and Cost Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month;
2. In the case of marriage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event; and
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event; and
4. In the case of new access to an ICHRA or new provision of a QSEHRA, if the Plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the Plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following the Plan selection.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation dissolution of domestic partnership or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment;
6. Individual who no longer resides, lives or works in the Plan's Service Area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. Termination of employer contributions; or
9. Exhaustion of COBRA or State continuation benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

1. Failure to pay Premiums on a timely basis, including COBRA or State continuation Premiums prior to expiration of COBRA or State continuation coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, dissolution of a domestic partnership, death, changes in income, change of Dependent's impairment or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family coverage should be changed to single coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to single coverage. The Exchange must be notified when a Member becomes eligible for or enrolled in Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Report life changes and qualifying life events to healthcare.gov:
https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete and understand that all rights to benefits under this Certificate are subject to the condition that all such information is accurate. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

WHEN MEMBERSHIP ENDS (TERMINATION)

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, move outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange as an overage Dependent. Coverage for Dependent children ends on the last day of the Benefit Year in which the child turns age 26;
4. The Member fails to pay his or her Premium, and the grace period has been exhausted;
5. Rescission of the Member's coverage;
6. The QHP terminates or is decertified;
7. The Member changes to another QHP;
8. The Member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange; or
9. The QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

"Grace period" refers to either:

1. The three month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the three month grace period; or
2. Any other applicable grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP Issuer, if the Member's QHP Issuer is able to implement termination in fewer than 14 days and the Member requests an earlier termination Effective Date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination Effective Date.
4. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange as an overage Dependent, coverage for Dependent children ends on the last day of the Benefit Year in which the child turns age 26.
5. In the case of a termination for non-payment of Premium and the three month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the three month

grace period.

6. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid, consistent with existing State laws regarding grace periods.
7. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
8. The day following the Member's death. When a Subscriber dies, the surviving spouse or domestic partner of the deceased Subscriber, if covered under the Certificate, shall become the Subscriber.

"Reasonable notice" is defined as 14 days prior to the requested Effective Date of termination.

Guaranteed Renewable

Coverage under this Certificate is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Certificate by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Certificate;
3. This Certificate has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP Issuer any information requested regarding Your eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two Years after the Effective Date of this Certificate, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on the application, We may terminate or rescind this Certificate as of the original Effective Date. Additionally, if within two years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependent did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give You at least 30 days written notice prior to rescission of this Certificate.

This Certificate may also be terminated if You engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Certificate. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two Years following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Coverage

We can refuse to renew Your Certificate if We decide to discontinue a health coverage product that We

offer in the individual market. If We discontinue a health coverage product, We will provide You with advance notice of the discontinuation as required by law. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the three month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Certificate is terminated. In order for a Premium to be considered paid during the grace period, We must receive it by the last day of the grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Premium Not Received on Time

If Premiums are not paid within the grace period, coverage under this Certificate will automatically terminate. Where the law allows, and subject to the grace period section of this Certificate, termination may be effective retroactively to the last date of the period for which Premium has been paid. We will not pay for any services provided to Members on or after the date of termination. All claims paid after termination will be retroactively adjusted.

We will mail written notice of any intention not to renew this Certificate beyond the period for which the Premium has been accepted not less than 30 days prior to the Premium due date. We will mail the notice to the Subscriber's latest address in Our membership records. A grace period will be granted for the payment of each Premium falling due after the first Premium, during which grace period the Certificate shall continue in force.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the three month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Our right to terminate the Certificate as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the three month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Certificate has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Certificate will stay in force and claims will be pended unless prior to the date Premium is due You give timely written notice to Us that the Certificate is to be terminated. If You do not make the full Premium payment during the grace period, the Certificate will be terminated on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the last day through which Premium is paid.

After Termination

Once this Certificate is terminated, the former Members cannot reapply until the next annual open

enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Members Entitled to or Enrolled in Medicare

Applicants who are not currently enrolled in Medicare and who reside in Nevada are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment in this HMO Nevada plan but who later becomes entitled to (and automatically enrolled in) Medicare Part A or enrolled in and pays their own premiums for Medicare Parts B, C and/or Part D, may continue coverage with this HMO Nevada plan coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

Duplicate Coverage

If a Member is covered under this Certificate and is also covered by another HMO Nevada individual Certificate, the Member is limited to the one Certificate elected by the Member, the Member's beneficiary or the Member's estate, as the case may be, and We will return all Premiums paid for all other such policies. However, We will deduct any benefits paid under the individual Certificate from the Premiums being refunded.

Insurance Premiums

How Premiums are Established and Changed

Premiums are the monthly charges the Member must pay Us to establish and maintain coverage. The Premium for this Certificate may change subject to, and as permitted by, applicable law.

Prior to a Premium change, We will send out written notification at least 60 days prior to open enrollment. We are not required to notify the Member of a Premium increase when a Member enters into a new age bracket. If the Member's Premium is paid beyond the Effective Date of the change, We may require the Member to pay an additional Premium or accept a refund, whichever is necessary. If the age of the Member is misstated, all amounts payable for the correct age shall be adjusted and billed to the Member.

It is the Subscriber's responsibility to pay Premiums to Us. Under no circumstances will Premium payments made on any Member's behalf or any Member be accepted from a doctor, a Hospital or any other Provider of the Subscriber's healthcare services or any federal or State agency. The receipt of a Premium payment from such a Provider or agency may result in termination of the Subscriber's coverage.

Note: We may offer incentives to Members who enroll to automatically pay Premiums electronically instead of receiving a paper bill every month.

The Subscriber must notify Us of an address change by submitting an Enrollment Application/Change Form, visiting Our website at www.anthem.com, or calling Our Member Services department. Failure to receive a Premium notice due to an unreported address change (or any other reason) does not relieve the Member from the responsibility to pay required Premiums by the Premium due date.

Changes in Premiums

The Premium rates are guaranteed for the 12 month period following the first day of the Calendar Year.

The Premium for this Certificate may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records at least 60 days prior to such change. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Payment of the Premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the

change.

How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- online at www.anthem.com
- by mail using the address on Your Premium notice
- by authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application

To learn more about any of these options, please contact Member Services at the number on the back of Your Identification Card.

Electronic Funds Transfer

If You submit a personal check for Premium payment, You automatically authorize Us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless You have given Us prior authorization to do so.

Administrative Fee

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Us for any reason.

Premiums Paid by a Third Party

We will accept Premium payments made on behalf of Subscribers if the Premium is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium and Cost Sharing support for specific individuals;
- Indian tribes, tribal organizations and urban Indian organizations; or
- A relative or legal guardian on behalf of a Subscriber.

Unless required by law, We do not accept Premium payments from third parties that are not listed above. Examples of third parties from whom We will not accept Premium payments include, but are not limited to, Providers, Hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan.

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 Plan, 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 Plan. We reserve the right to discontinue a pilot or test program at any time.

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 Certificate are not part of the contract between the parties and do not give rise to contractual obligations.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

Notice of Privacy Practices

We are committed to protecting the confidential nature of Members' medical information to the fullest extent of the law. In addition to various laws governing Member privacy, We have Our own privacy policies and procedures in place designed to protect Member information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website or contact Our Member Services department.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process Your 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. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

Refusal to Follow Recommended Treatment

If a Member refuses treatment that has been recommended by Our In-Network Provider, the Provider may decide that the Member's refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a Member's wishes, when they are consistent with the Provider's judgment. If a Member refuses to follow the recommended treatment or procedure, the Member is entitled to see another Provider of the same specialty for a second opinion. The Member can also pursue the Appeal process.

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 healthcare coverage. Members can help decrease these costs by doing the following:

- Be wary of offers to waive Copayments or Deductible. This practice is usually illegal.
- Be wary of mobile health testing laboratories. Ask what the insurance company will be charged

for the tests.
- Always review the Explanation of Benefits received from Us. If there are any discrepancies, call Our Member Services department.
- Be very cautious about giving the Member's health insurance coverage information over the phone.

If fraud is suspected, Members should contact Our Member Services department.

Misstatement of Age

If the Premium for this contract is based on Your age and if Your age has been misstated, the benefits will be those the Premium paid would have purchased at the correct age.

Notice

Any notice given by Us to a Subscriber shall be sufficient if mailed to the Subscriber at his or her address as it appears in Our records. Notice given to Us must be sent to Our address as shown in this Certificate, or a Member may, by written notice, indicate a new address for giving notice.

Not Liable for Provider Acts or Omissions

We are not liable for the acts or omissions by any individuals or institutions furnishing care or services to You.

No Withholding of Coverage for Necessary Care

We do not pay, reward or incent, financially or otherwise, Our associates for inappropriate restrictions of care. We do not promote or otherwise provide a reward to employees or doctor reviewers for withholding benefit approval for Medically Necessary Covered Services to which You are entitled. Utilization Review and benefit coverage decision making is based on appropriate care and service and the terms of this Certificate.

We do 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 healthcare Providers or Members.

Paragraph Headings

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

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably be required during the pendency of a claim and to make an autopsy in case of death where it is not prohibited by law.

Reserve Funds

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

Severability

In the event that any provision in this Certificate is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Certificate will remain in force and effect.

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.

Right to Change Plan

No agent or employee of the Plan or other person, except an authorized officer of the Plan, has authority to waive, even if by providing incomplete or incorrect information, any conditions or restrictions or to change the form or content of this Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information. Such changes can be made only through a written amendment or endorsement, signed by an officer of the Plan.

Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, the Member must pursue the Member's rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an Appeal with the Nevada Division of Industrial Relations. We may pay conditional claims during the Appeal process if the Member signs a reimbursement agreement to reimburse Us for 100 percent of benefits paid that duplicate benefits paid from another source.

Services and supplies resulting from work-related illness or injury are not a benefit under this Certificate, except for corporate officers who have opted out of Workers' Compensation coverage, pursuant to State or federal law, prior to the illness or injury. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness covered under:

- Occupational disease laws.
- Employer's liability insurance.
- Municipal, State, or federal law.
- Workers' Compensation Act.

We will not pay benefits for services and supplies resulting from a work-related illness or injury **even if other benefits are not paid because:**

- The Member fails to file a claim within the filing period allowed by the applicable law.
- The Member obtains care that is not authorized by workers' compensation insurance.
- The Member's employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work related illness or injury expenses.
- The Member fails to comply with any other provisions of the Workers' Compensation Act.

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 healthcare 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.

Medical Policy and Technology Assessment

We review and evaluate 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 Our medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including 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.

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, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. 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 We offer the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue an incentive or a program 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.

Value-Added Programs

We may offer health or fitness related programs and products to Our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on Pharmacy products (over the counter drugs, consultations and biometrics). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Certificate 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. Your participation in a program is optional and at no charge from Us. Visit Our website, www.anthem.com for information about programs, including how to obtain program services, how to find replacement services if a program vendor no longer provides services, and other useful information.

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.)

Members' Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit Plan. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, HMO Nevada 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" > "Select My State"> "Laws and Rights That Protect You" > "What are my rights as a member?". Members or Providers who do not have access to the website can request copies by contacting HMO Nevada, or by calling the number on the back of the Member ID Card.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Certificate so they are easy to identify.

Advance Payments of the Premium Tax Credit (APTC)

Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian

An individual who is a Member of a federally recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the "If You Have a Complaint or an Appeal" section of this Certificate.

Authorized Service(s)

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the In-Network level. For more information, see the "How Your Claims Are Paid" section.

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/Year

The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a Calendar Year for this Plan, as listed in the "Schedule of Cost Share and Benefits." If Your coverage ends earlier, the Benefit Period/Year ends at the same 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.

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 difference from the reference product.

Brand Drugs

Prescription Drugs that We classify as Brand Drugs or Our PBM has classified as Brand Drugs through use of an independent proprietary industry database.

Calendar Year

A period beginning on January 1 and ending on December 31 of the same Year.

Certificate of Coverage (Certificate)

This summary of the terms of Your benefits.

Coinsurance

The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

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.

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 for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service. The Copayment does not apply to the Deductible.

Cost Share (Cost Sharing)

The amount which the Member is required to pay for Covered Services. Where applicable, Cost Share can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the "What is Covered" section;
- Within the scope of the Provider's license;
- Rendered while coverage under this Certificate is in force;
- Not Experimental or Investigational or not covered by this Certificate; and
- Authorized in advance by Us if such preauthorization is required in Certificate.

Custodial Care

Care primarily for Your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, giving medicine which You usually do Yourself or any other care for which services of a Provider are not needed.

Deductible

The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your "Schedule of Cost Share and Benefits".

Dependent

A Member of the Subscriber's family who meets the rules listed in the "When Membership Changes (Eligibility)" section and who has enrolled in the Plan. Please see "Newborn and Adopted Child Coverage" 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.

Durable Medical Equipment

Any equipment that can withstand heavy use to serve a medical need, is useless to a person who is not

sick or hurt, and is appropriate for use at home.

Effective Date

The date when a Member's coverage begins under this Certificate.

Emergency

The sudden onset of a medical condition or accident manifesting itself in 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.
- Serious jeopardy to the health of an unborn child.
- Serious impairment to bodily functions.
- Serious and permanent dysfunction of any bodily organ or part.

Emergency Medical Condition (Emergency)

A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- placing the health of the individual or another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care)

With respect to an Emergency Medical Condition:

1. A medical or behavioral health screening examination that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and
2. Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

The term "**stabilize**" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Exchange

A governmental agency or non-profit entity that makes Qualified Health Plans such as this Plan available to Qualified Individuals.

Experimental or Investigational

(a) 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 We determine in Our sole discretion to be Experimental or Investigational.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental or Investigational if We determine 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 as noted in the Clinical Trials subsection under the "What is Covered" section in this Certificate as required by State 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; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or 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.

(b) Any service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Us. In determining whether a service is Experimental or Investigational, We 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; or
- 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.

(c) The information We consider or evaluate 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 doctors, other medical professionals or facilities, or by other treating doctors, 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 doctors, other medical professionals or facilities or by other treating doctors, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

(d) We have 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 surgical Facility, Residential Treatment Center, or Skilled Nursing Facility, as defined in this Certificate. The Facility must be licensed as required by law, satisfy Our accreditation requirements, and approved by Us.

Generic/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 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.

Habilitative Services

Healthcare services and devices that help a person 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.

HMO Nevada

A health maintenance organization, organized under the laws of the State of Colorado, as HMO Colorado, Inc., doing business in Nevada as HMO Nevada. HMO Nevada is an expansion of HMO Colorado, Inc., a Colorado corporation licensed to do business in Nevada as HMO Nevada. Referred to in this Certificate as “Us”, “We”, or “Our.”

Home Delivery Pharmacy

A service where You get Prescription Drugs (other than Specialty Drugs) through a mail order service.

Home Healthcare Agency

A Facility, licensed in the state in which it is located, which:

- Provides skilled nursing and other services on a visiting basis in the Member’s home; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending doctor.

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

A card issued by the Plan that bears the Member’s name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

In-Network

Terms for Providers or facilities that enters into an In-Network agreement with Us for this specific health benefit Certificate. Our Provider network does not include all Providers who are In-Network for Our other health benefit plans. A Member may find out whether a Provider is In-Network for Our health benefit plans by checking Our Provider directory at www.anthem.com.

In-Network Pharmacy

An In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In-Network Pharmacies may be based on a restricted network, and may be different than the network of In-Network Pharmacies for Our other products. To find an In-Network Pharmacy near You, call Pharmacy Member Services at the telephone number on the back of Your Identification Card.

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 under this Plan.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

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 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 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.

Maintenance Medication

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 Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the "How Your Claims Are Paid" section.

Medicaid

Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

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 We, subject to a Member's right to Appeal, as described in the "If You

Have A Complaint Or An Appeal" section, 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 doctor 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 doctor'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 Certificate.

The fact that a doctor 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.

Medicare

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

The Subscriber and enrolled Dependent.

Mental Health and Substance Use

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 condition.

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as State high risk pool coverage, or as the Secretary of HHS recognizes.

Out-of-Network

A term for Providers or facilities that do not enter into a network agreement with Us, usually at a higher out-of-pocket expense to Members than services rendered by an In-Network Provider. Services from Out-of-Network Providers are covered only under limited circumstances. However, Out-of-Network Providers are subject to the Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers.

Out-of-Network Pharmacy

A Pharmacy that does not have an In-Network Pharmacy agreement in effect with or for the benefit HMO Nevada at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out-of-Network Pharmacy.

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 through negotiated payment arrangements under this Plan. You will often get a lower level of benefits when You use Out-of-Network Providers.

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 healthcare that Your Plan doesn't cover. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Certificate. Please see the "Schedule of Cost Share and Benefits" for details.

Outpatient

A Member who receives services or supplies when not an Inpatient.

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 Our behalf. Our PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

Our 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.

Plan

The set of benefits, conditions, exclusions and limitations described in this document.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Premium

The monthly charge You must pay Us to establish and maintain coverage under this Certificate.

Prescription Drug

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes insulin, diabetic supplies, and syringes.

Prescription Drug List

Listing of Prescription Drugs that are determined by Us in its sole discretion to be designated as covered drugs. The List of approved Prescription Drugs developed by Us in consultation with doctors and pharmacists has been reviewed for their quality and cost effectiveness. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the formulary for Our other products. Generally, it includes select Generic Drugs with limited Brand Drug coverage. This list is subject to periodic review and modification by Us. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. A description of the Prescription Drugs that are listed is available upon request and at www.anthem.com

Prescription Order (Prescription)

A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP")

A Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics, gynecology, geriatrics or any other In-Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Provider

A professional or Facility licensed by law that gives healthcare services within the scope of that license, that must satisfy Our accreditation requirements and be approved by Us. Details on Our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/ . This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Certificate. If You have a question about a Provider not described in this Certificate please call the number on the back of Your Identification Card.

Qualified Health Plan or QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer (QHP Issuer)

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Referral

A specific recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Provider. A recommendation from a Provider is a Referral only to the extent of the specific services approved by the PCP on the written Referral form or by other notification methods prescribed by HMO Nevada for use by PCPs. A general statement by a PCP that a Member should seek

a particular type of service or Provider does not constitute a Referral under this Certificate.

Rehabilitative Services

Healthcare services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Residential Treatment Center

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use 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 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 Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Drugs) through a licensed pharmacist or Home Delivery Pharmacy service upon an authorized healthcare professional's order.

Self-Administered Drugs

Drugs that are administered which do not require a medical professional to administer.

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) 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 health benefit Plan is offered. This Plan is only available in certain areas. For a list of the specific counties within the Service Area, contact Us or Your broker.

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.

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.

Specialty Care Physician (Specialist or SCP)

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 healthcare.

Specialty Drugs

Drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at Retail Pharmacies.

Specialty Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

Each of the 50 States and the District of Columbia.

Subscriber

The Member who applied for coverage and in whose name this Certificate is issued.

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.

Tax Dependent

Tax Dependent has the same meaning as the term Dependent under the Internal Revenue Code.

Tax Filer

Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

1. To file an income tax return for the Benefit Period
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Period;
3. That no other taxpayer will be able to claim him, her or them as a Tax Dependent for the Benefit Period; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her Spouse.

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.

Urgent Care

Medical care for an unexpected illness or injury 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 Care Center

A licensed healthcare 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.

We, Us and Our

Is HMO Nevada.

Year and Yearly

A 12 month period.

You and Your

The Member, Subscriber and each covered Dependent.

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 장애인이신가요? 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 fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا 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
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ 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 uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

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