

Our plans fit your plans



ClearProtection™



Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

For over 40 years, Anthem has provided health care coverage and security to our Nevada neighbors. And now, we're pleased to offer these same individual health care plans with added benefits and features of the Patient Protection and Affordable Health Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Sounds like a plan.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in Nevada.**
With more than 2,500 doctors and nearly 40 hospitals throughout the state, chances are your doctor is one of ours.
- **A choice of plans to fit your budget and lifestyle.**
No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- **Optional dental and term life insurance.**
To enhance your health and your family's financial future, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.**
No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.

Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. Not only does health coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Some definitions so we're all on the same page

Network Discounts: With Anthem Blue Cross and Blue Shield you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 2,500 doctors and nearly 40 hospitals, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost-Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem Blue Cross and Blue Shield can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the costs, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year (annually) for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment (or Copay) is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for network covered services. Once you reach this maximum, the plan pays at 100% for most services for the rest of the calendar year.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Specialty Drugs are typically high cost, scientifically engineered drugs used to treat complex, chronic conditions. They require special handling and usually must be shipped directly to the user.

Formulary is a list of prescription drugs our health care plans cover. They include generic, brand name, and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

ClearProtectionSM Is this the right plan for you?

ClearProtection is one of our lower-priced plans with an innovative plan design that helps limit your share of the costs for major medical expenses, such as surgery and hospitalizations. In addition:

- You'll have immediate benefits for your first two doctors' office visits.
- There are two deductibles that work together to help you meet your out-of-pocket maximum.
- Once your out-of-pocket maximum is met, the plan pays 100% of the costs for most network covered services.

ClearProtection Plan Highlights

This plan offers a valuable combination of affordable coverage with some immediate benefits, plus a broad range of benefits once the out-of-pocket maximum is met.

Features:

- Some of our lowest monthly rates and immediate coverage for first two doctors' office visits.
- Access to discounts on ALL covered services from network providers while meeting your out-of-pocket maximum.
- 100% coverage for most network covered services once your out-of-pocket maximum is met.
- Coverage for generic and brand name prescription drugs.
- Preventive care benefits help focus on keeping you healthy.

You should know:

- This plan features two deductibles that work together to help you meet your total out-of-pocket maximum.
- Deductibles for Network and Non-Network covered services are the same dollar amount and accumulate separately. The same is true for Out-of-Pocket Maximums.
- This plan has its own Drug Formulary.
- Maternity benefits are not included with this plan.

Prescription Drug Coverage

The ClearProtection covers both generic and brand name prescription drugs. This plan also uses a special Formulary which is posted at www.wellpointnextx.com/Formulary1.

How ClearProtection Works

ClearProtection has two deductibles:

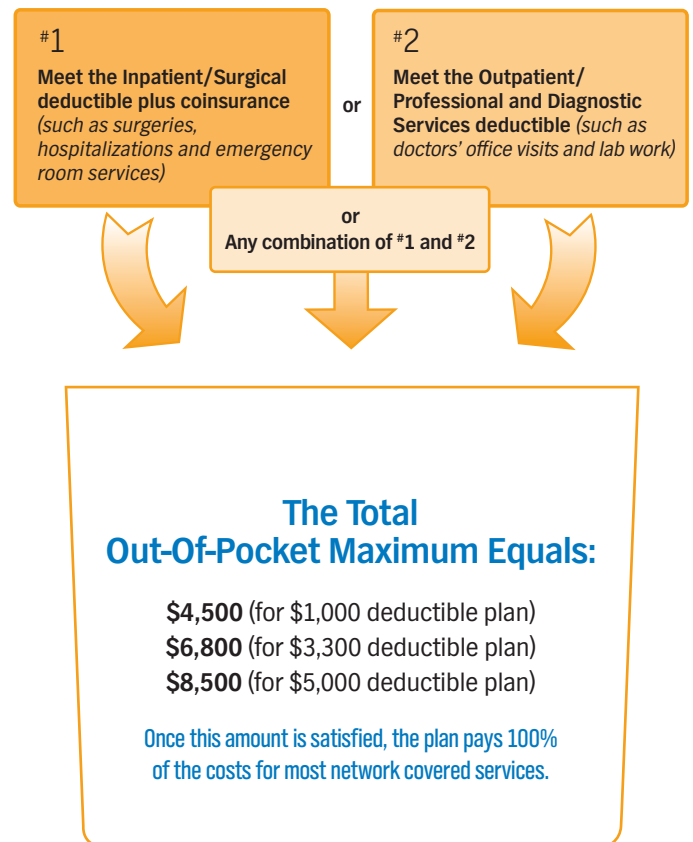
1. INPATIENT/SURGICAL SERVICES

This is the lower of the two deductibles to help you access benefits faster for these higher-cost services.

2. OUTPATIENT/PROFESSIONAL AND DIAGNOSTIC SERVICES

This deductible is equal to your out-of-pocket maximum. So even if you only use outpatient services, once you meet this deductible, you will have also met your out-of-pocket maximum.

These two deductibles work together to help you reach your total out-of-pocket maximum. Depending on your health care needs, you can satisfy your total out-of-pocket maximum in any of the following ways:



Note: Deductibles and Out-of-Pocket Maximums are based on a calendar year (January 1 - December 31).

Benefits

ClearProtectionSM

Calendar Year Deductible

Deductibles for Network and Non-Network covered services are the same dollar amount and accumulate separately.

Individual	\$1,000 or \$4,500	\$3,300 or \$6,800	\$5,000 or \$8,500	For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services
Family	\$2,000 or \$9,000	\$6,600 or \$13,600	\$10,000 or \$17,000	For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services
Network Coinsurance Options	30% 0%	30% 0%	30% 0%	For Inpatient/Surgical and Emergency Room Services For Outpatient/Professional and Diagnostic Services

Calendar Year Out-of-Pocket Maximum

ALL COVERED SERVICES, IN ANY COMBINATION, APPLY TOWARD YOUR OUT-OF-POCKET MAXIMUM BELOW
This is the maximum you'll pay for most network covered services each calendar year; then the plan pays 100%. Out-of-Pocket Maximums for Network and Non-Network covered services are the same dollar amount and accumulate separately.

Individual	\$4,500	\$6,800	\$8,500	(these amounts include the deductibles)
Family	\$9,000	\$13,600	\$17,000	(these amounts include the deductibles)

How family deductibles and family out-of-pocket maximums work

Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.

Plan Lifetime Maximum

Unlimited

Covered Services

Your Share of Costs (after deductible, if applicable)

Doctors' Office Visits	NETWORK: First 2 Office Visits (per member): \$40 Copay , deductible waived Additional Office Visits: 100% of negotiated fee ; then 0% Coinsurance after out-of-pocket maximum is met NON-NETWORK: 100% Coinsurance ; then 0% Coinsurance after out-of-pocket maximum is met
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	NETWORK: Inpatient: 30% Coinsurance Outpatient: 100% of negotiated fee ; then 0% Coinsurance after out-of-pocket maximum is met NON-NETWORK: Inpatient: 50% Coinsurance Outpatient: 100% Coinsurance ; then 0% Coinsurance after out-of-pocket maximum is met
Inpatient Services (overnight hospital/facility stays)	NETWORK: 30% Coinsurance NON-NETWORK: 50% Coinsurance after Deductible , then 0% Coinsurance after out-of-pocket maximum is met
Outpatient Services (without overnight hospital/facility stays)	NETWORK: Surgery: 30% Coinsurance Other Services: 100% of negotiated fee ; then 0% Coinsurance after out-of-pocket maximum is met NON-NETWORK: 100% Coinsurance after Deductible , then 0% Coinsurance after out-of-pocket maximum is met
Emergency Room Services	NETWORK: 30% Coinsurance PLUS \$100 Emergency Room Copay (Copay waived if admitted) NON-NETWORK: 30% Coinsurance PLUS \$100 Emergency Room Copay (Copay waived if admitted)
Preventive Care Services	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more. NETWORK: 0% Coinsurance, not subject to deductible NON-NETWORK: 50% Coinsurance, deductible waived
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life

Prescription Drug Coverage

ClearProtection¹

Retail Drugs (and Mail Order Drugs when available)	NETWORK: Tier 1 (Generic drugs): \$15 Copay \$7,500 annual Prescription Drug deductible per member for Tier 2/Specialty drugs applies before the following: · Tier 2 (Formulary Brand name drugs): \$35 Copay · Specialty: 25% Coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), for network only and in addition to \$7,500 annual deductible. · For Drugs Not on Formulary: Not covered, discounts apply. NON-NETWORK: Same benefits as network plus any difference in cost between the actual charges and Anthem's allowed amount.
Optional Drug Coverage (when available)	Not Available

Other Covered Benefits include but are not limited to:

Ambulance, Home Health Care, Physical/Occupational Therapy, Urgent Care

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Policy. In the event of a conflict between the Policy and this Benefit Guide, the terms of the Policy will prevail.

¹ ClearProtection has its own Plan Formulary.

NOTES: Discounted network rates apply for network covered services. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount. Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Policy.



Give yourself every advantage...

Good health, a bright smile and financial support.

Dental Coverage

Our Anthem Blue Dental PPO plan includes coverage for the basics, plus certain services like crowns, root canals and dentures. If you need a dental plan that offers important preventive services and a broad range of benefits, this could be the right plan for you.

Save money by using our dental network

We have more than 2,100 participating dental PPO dentist locations in Nevada to choose from. While our dental PPO plan allows you to go to *any* dentist, you may save the most money when you choose one of the dentists in our PPO provider network. Even better, when you visit a network dentist, you have no deductible or coinsurance to pay for any covered diagnostic or preventive service. For basic and major services, the calendar-year deductible is \$50 per person (up to three deductibles per family) and must be satisfied before we will pay any benefits.

Diagnostic and Preventive Care

Coverage for routine check-ups, X-rays and cleanings begins the day your policy is effective.

Diagnostic and Preventive Care		
Procedure	Plan Pays	
	Network	Non-network
Periodic oral exams, routine cleanings and X-rays <small>(cleanings limited to two per member per year)</small>	100%	Fee Schedule*

Basic Dental Care

Coverage for fillings begins after six months of continuous coverage.

Basic Dental	
Procedure	Plan Pays
	Network or Non-network
Fillings (one surface, permanent)	\$42
Fillings (two surfaces, permanent)	\$54
Extraction, simple (erupted tooth or exposed root)	\$39

Major Dental Care

Coverage for major dental care begins after 12 months of continuous coverage.

Major Dental	
Procedure	Plan Pays
	Network or Non-network
Scaling/root planing per quadrant	\$43
Root Canal (one canal)	\$127
Crown (except stainless steel)	\$225
Complete denture (upper or lower)	\$300

*For more details and a copy of our non-network fee schedule, please contact your Anthem agent.

Calendar Year Maximum Benefit

During each calendar year, the Anthem Blue Dental PPO plan provides up to \$1,000 of benefits for each enrolled member.

Term Life Insurance

Losing a loved one is painful enough without having to worry about finances. Give your family extra support with term life insurance from Anthem Life Insurance Company.

If you're accepted for coverage on one of our health care plans, you'll automatically be approved for our term life insurance. Plus, there are no medical exams or additional enrollment forms to worry about. It's that simple.

Term life monthly rates					
Age	\$15,000 Benefit	\$25,000 Benefit	\$50,000 Benefit	\$75,000 Benefit	\$100,000 Benefit
1-18	\$1.50	\$2.50	N/A	N/A	N/A
19-29	\$2.80	\$4.65	\$9.30	\$11.25	\$13.00
30-39	\$3.25	\$5.40	\$10.80	\$13.50	\$16.00
40-49	\$7.50	\$12.50	\$25.00	\$33.75	\$42.00
50-59	\$20.90	\$34.80	\$69.60	\$97.50	\$125.00
60-64	\$29.40	\$49.00	\$98.00	\$142.50	\$185.00

It's That Simple...

Additional Information

"No Obligation" review period

After you enroll in an Anthem plan, you'll receive a Certificate that explains the terms and conditions of coverage, including the plan's exclusions and limitations. You have 30 full days to examine your plan's features. During that time, if you're not fully satisfied, you may decline coverage by returning your Certificate along with a letter notifying us that you want to discontinue coverage. You'll receive a full refund of any premium you've paid, less any claims we've paid on your behalf. Certificates are available to examine before enrolling. Ask your agent or Anthem.

Save time with automatic premium payment

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health care plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.



Ready to choose a plan?

- After reviewing all the materials included with this brochure, contact your Anthem agent.
- Ask questions. If you aren't sure about how a plan works or have additional questions, your agent will help you.
- Fill out an application. The quickest and easiest way to complete an application is online and your agent can assist you. Or your agent can provide you with instructions for mailing or faxing your application.

**If you have questions
or want more details
about your options, call
your Anthem agent today!**





Health. Join In.

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan(s) described – including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem agent.

This brochure is intended as a brief summary of benefits and services; it is not your Certificate/Summary of Benefits. If there is any difference between this brochure and your Certificate/Summary of Benefits, the provisions of the Certificate/Summary of Benefits will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Ready to enroll?

Call your Anthem agent today!

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Nevada Coverage Details

Things you need to know before you buy...

SmartSense Plus,[®] CoreShare,SM Premier, Lumenos[®] HSA Plus and ClearProtectionSM

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

To enroll, you must be:

- Age 64 3/4 or younger
- A permanent legal resident of Nevada

Medical Underwriting Requirement

We believe the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem offers various levels of coverage. To determine individual medical risk factors, all enrollments are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium rate
- You may be offered the plan you selected at a higher rate
- You may not qualify for the plan(s) listed in the brochure
- You may be offered an alternate plan

If you have a significant medical condition and don't qualify for the plan you've chosen or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

Rate Determinations

For Individual policies, rates are determined as follows:

- Rates are based on age, gender, benefit plan, family size, geographic location and tobacco use.
- For families with more than three children, the family rate is capped at three children.
- When a member or spouse attains an age that requires a rate change to a new category, the adjustment will be made on the policy anniversary date and the premium will be automatically adjusted to the new rate.
- Rates are subject to change with 60-day written notice.

Waiting Periods

For applicants age nineteen (19) and older there is a 12-month waiting period for coverage of any health condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received within 6 months preceding the coverage effective date. If you apply for coverage within 63 days of terminating your membership with another 'creditable' health care benefits plan, you may use your prior coverage for credit toward the 12-month waiting period. Anthem will credit the time you were enrolled in the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen (19). Consult with your Anthem agent or representative if you have a question about the underwriting process.

Guaranteed Renewability Of All Individual Health Policies

Anthem will not cancel or refuse to renew any Individual policy, except for the following reasons:

- Nonpayment of premium

- Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the insured
- Anthem elects to discontinue offering all Individual policies
- The state insurance commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders
- The state insurance commissioner finds that the product form is obsolete and is being replaced with comparable coverage

Nevada Summary Of Benefits Form

Nevada law requires carriers to make available a Nevada Summary of Benefits Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, on oral or written request, within three business days to any person who is interested in coverage under, or who is covered by, a health care benefits plan of the carrier. If you would like a copy of the state mandated Nevada Summary of Benefits Form, which provides information on health plan benefits, provider contract arrangements and other information, please contact your Anthem agent. For complete details about benefits, procedures, limitations and exclusions, please refer to the Summary of Benefits Form and Certificate. In the event of a conflict between anything printed in this document and the Certificate, the terms of the Certificate will prevail.

Terms Of Coverage

Coverage remains in force as long as you pay the required premiums on time and for as long as you remain eligible for membership. Coverage will cease if you become ineligible due to:

- Residency requirements and/or
- Duplicate Individual coverage with Anthem

We may change rates with at least 60-day advance written notice. We may change coverage or benefits with 90-day advance written notice. Anthem does not change coverage or rates unless the change applies to all covered persons of the same class.

Access To The Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Anthem or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

Anthem, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The

UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

Medical Exclusions And Limitations

The following information will help you understand what your health care plan does not include before you enroll. This is an overview only. For a complete list of exclusions and limitations, you can request a copy of the plan's Summary of Benefits Form and Certificate. Just ask your Anthem agent for a copy.

Our Plans Do Not Cover

- Normal maternity and pregnancy care
- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state, federal or foreign government
- Services or supplies not specifically listed as covered in the Certificate
- Services received before your plan effective date or after coverage ends, except as stated in your Certificate
- Personal comfort items

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- Custodial care
- Services or supplies related to sex change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation
- Cosmetic surgery
- Services primarily for weight reduction
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Certificate
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered), except as specifically stated in the Certificate
- Infertility services
- Eyeglasses or contact lenses
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Certificate
- Services received for mental and nervous disorders and substance abuse, except as specifically stated in the Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Certificate
- Nutritional counseling, food, or dietary supplements except for formulas and special food products to prevent complications of phenylketonuria (PKU) and inherited enzymatic disorders as stated in the certificate
- Genetic testing
- Hearing aids or routine hearing tests
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Certificate
- Outpatient speech therapy, except as specifically stated in the Certificate
- Private duty nursing
- Services or supplies related to a pre-existing condition, for applicants age nineteen and older
- Educational services except as provided for or arranged by Anthem
- Telephone or Internet consultations
- Any services received by Medicare benefits without payment of additional premium
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Services or supplies that are not medically necessary

Premier and SmartSense Plus plans do not cover obesity surgery.

Lumenos Plus does not cover skilled nursing facility care.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem agent to request them.

The Summary of Benefits Form and/or Certificate are also available for you to examine before enrolling. Ask your Anthem agent or Anthem.