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Short-term Plans

For Individuals and Families

Nevada

Anthem Blue Cross and Blue Shield's Short-term Plans

Whether you've just graduated from college, are between jobs or are waiting for permanent coverage at your new job, Anthem Blue Cross and Blue Shield's short-term plans offer the immediate coverage you need.

We offer coverage from 30 to 180 days, deductibles from $250 to $2,000, and the ability to begin or end coverage any day of the month.

Our short-term plans provide coverage you can count on, with comprehensive benefits, convenience and access to one of the state's largest provider networks—all at very competitive rates. But most importantly, our plans are backed by the strength, stability and security of Anthem Blue Cross and Blue Shield, one of Nevada's largest insurers and one of the most trusted names in health care benefits.

Maximum Coverage Period

Short-term plans allow you to decide how long you'll need coverage—from a minimum of 30 days to a maximum of 180 days. The plans are nonrenewable and are designed to meet your temporary health plan needs while you're waiting for permanent coverage.

After your plan expires, you may complete a new application and re-apply for a new plan. However, once you've completed two coverage periods with less than a six-month lapse between the coverage periods, you must wait six months to be eligible to apply for another short-term plan.

Eligibility and Enrollment

To qualify for coverage, you must be:

- 15 days to 64½ years old.
- A resident of Nevada.
- A resident of the United States for at least six months.

To qualify for dependent coverage, your dependent(s) must be:

- Your lawful spouse up to age 64½,
- Your (or your spouse's) child(ren) between the ages of 15 days and 19 years, or
- Your (or your spouse's) unmarried dependent child(ren) between the ages of 19 and 24 (eligible as dependents only if they are unmarried and full-time students).

Pricing is based on a per member per day rate. Please remit your check, made payable to Anthem Blue Cross and Blue Shield, for the entire premium with your application. For faster service, you may also choose to pay by credit card and submit your application via fax. We accept VISA® and MasterCard®.

Application Fee

Individual coverage: You must submit a separate, nonrefundable $10 application fee with your application.

Family coverage: You must submit a separate, nonrefundable $10 application fee with each application, unless you're submitting separate applications at the same time in the same envelope. In that case, only one $10 nonrefundable application fee is required.

Application fees are payable by check or credit card.

Effective Date of Coverage

The coverage effective date is determined by the date you choose to start coverage in accordance with the terms of the policy and acceptance by Anthem Blue Cross and Blue Shield. In most cases, if accepted by Anthem, coverage takes effect at 12:01 a.m. on the date following the U.S. Postal Service postmark date stamped on the envelope or on the date Anthem received your application or you requested to start coverage. If you pay by credit card and submit your application via fax, coverage may become effective as early as 12:01 a.m. the next day. **If you submit your application by fax, please don't also mail your application to Anthem**.

What the Plan Covers

Anthem Blue Cross and Blue Shield's short-term plans provide the benefits you need and then some. Please refer to the short-term benefit overview on pages 2 and 3 for details.

Network Advantages

You'll receive the highest level of benefits when you receive care from in-network providers. Anthem Blue Cross and Blue Shield offers one of the largest primary care and physician specialist networks in both northern and southern Nevada. And, you won't need to submit claim forms when you use in-network doctors and hospitals, which means less paperwork and more convenience for you.

We also provide out-of-network benefits. However, please keep in mind that your out-of-pocket costs will be lower when you obtain care from in-network providers.

Short-term Benefit Overview

This matrix provides a brief description of some of the plan features and reflects Anthem Blue Cross and Blue Shield's payment for covered services after applicable deductibles are met. When you use in-network providers, your costs are based on Anthem's specially negotiated rates that may often

Benefit
Deductible
Out-of-pocket Maximum Only payments to in-network providers apply to the out-of-pocket maximum.
Plan Maximum
Professional Services Office visits, surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-rays and lab work
Preventive Care Routine mammogram[1] and routine Pap test[2]
Physical Therapy, Occupational Therapy, Acupuncture/Acupressure
Inpatient Hospital Services All inpatient medical care requires preauthorization or the member will be subject to an additional $500 penalty. This penalty is waived for emergency admissions; however, utilization review is still required.
Initial Care for a Medical Emergency (inpatient or outpatient)
Outpatient Medical Care Non-emergency outpatient emergency room visits that do not result in inpatient admission will be subject to an additional $60 deductible.
Ambulatory Surgical Center All surgical services at an ambulatory surgical center require preauthorization or the member will be subject to an additional $50 penalty.
Home Health Care Maximum 30 visits per member per plan. Preauthorization is required; failure to obtain preauthorization will result in a 50 percent reduction in benefits.
Generic Drugs (maximum 30-day supply)[3,4]
Brand-name Drug Deductible
Brand-name Drugs (maximum 30-day supply)[3]
Brand-name Drug Maximum

[1] Office visit not covered
[2] Office visit covered
[3] Prescriptions may be filled only at retail pharmacies.
[4] There is no deductible for generic drugs.

save you money. When you use out-of-network providers, your costs are based on charges deemed by Anthem to be reasonable for that service and area. Reasonable charges may be less than the out-of-network provider's billed charges and often result in higher costs to you.

Anthem's share of costs for covered expenses after you meet applicable deductibles	
In-network Providers	**Out-of-network Providers**
$250, $500, $1,000 or $2,000 per member per plan	
$1,000 plus the medical deductible per member per plan	Out-of-pocket maximum doesn't apply.
$2 million	
80%	50%
80%	50%
$30 maximum per visit, with a combined maximum of 6 visits per member per plan term	
80%	50%
80%	80%
80%	50%
80%	50%
80%	50%
100% after member pays a $15 copayment	50% of the average wholesale price
$500	
60%	60% of the average wholesale price
Once Anthem has paid $1,000 for brand-name prescription drugs, your brand-name drug prescriptions will no longer be covered; however, you will still receive the Anthem network discount when you present your Anthem health plan ID card at the pharmacy.	

For a more detailed description of coverage, benefits, limitations and exclusions, utilization review, the preauthorization process, and penalties that may apply, please refer to the Summary of Coverage and policy for each plan. If there are any conflicts between the terms of the policy and the information in this brochure, the terms of the policy will prevail.

Exclusions and Limitations: What the Plan Does Not Cover

Every health plan has exclusions and limitations. Those listed below are an overview only. A comprehensive description of what is covered and what is not covered under the plan can be found in the Summary of Coverage and policy. The plan does not provide benefits for:

- Surgical procedures for sterilization (i.e., vasectomy and/or tubal ligation).
- Any amounts exceeding the allowable maximum amounts for covered services as stated in the Summary of Coverage and policy.
- Services not specifically listed in the Summary of Coverage and policy as covered services.
- Services or supplies that are not medically necessary as defined by Anthem Blue Cross and Blue Shield.
- Services or supplies that Anthem Blue Cross and Blue Shield considers experimental or investigational.
- Services received before the effective date of coverage or during an inpatient stay that began before that effective date.
- Services received after coverage ends.
- Services the member has no legal obligation to pay for or would not be charged for if the member did not have a health policy or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability or occupational disease law, even if the member doesn't claim those benefits.

- Conditions caused by: (a) an act of war; (b) the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy; (c) a member participating in the military service of any country; (d) a member participating in an insurrection, rebellion or riot; (e) services received as a direct result of a member's commission of, or attempt to commit, a felony or as a direct result of the member being engaged in an illegal occupation; (f) a member being under the influence of illegal narcotics or nonprescribed controlled substances, possession of which would constitute a felony, unless administered on the advice of a physician.
- Any services provided by a local, state or federal government agency, except when payment under the policy is expressly required by federal or state law.
- If a member is eligible for Medicare, any services covered by Medicare under Parts A or B, regardless of actual enrollment in Medicare or payment by Medicare for those services.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration hospitals and military treatment facilities will be considered for payment according to current legislation.
- Professional services received or supplies purchased from the member, a person who lives in the member's home or who is related to the member by blood, marriage or adoption, or any of the member's employers.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain; custodial care or rest cures; or services provided by a rest home, a home for the aged, a nursing home or any similar facility.

- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Treatment of mental, emotional or functional nervous disorders (including nicotine use) or psychological testing. However, medical conditions caused by the member's behavior and that may be associated with these mental conditions are not subject to these limitations.
- Dental services and dental implants.
- Orthodontic services.
- Hearing aids.
- Routine hearing tests.
- Optometric services and eye surgery to correct refractive defects.
- Outpatient speech therapy.
- Any drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the Summary of Coverage and policy. This includes, but is not limited to, items dispensed by a physician.
- Cosmetic surgery or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to reconstructive surgery to restore a bodily function or to correct a deformity caused by injury or congenital defect of a newborn child, or for medically necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction, impotence and/or inadequacy.

- All services related to the evaluation or treatment of fertility and/or infertility, including, but not limited to, all tests, consultations, examinations and medications and invasive, medical, laboratory and surgical procedures, including sterilization reversals and in vitro fertilization.
- Cryopreservation of sperm or eggs.
- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
- Services primarily for weight reduction or treatment of obesity, including morbid obesity, or any care that involves weight reduction as a main method for treatment.
- Immunizations.
- Services for well-baby and well-child care.
- Preventive care services, except preventive/routine mammograms and Pap tests, as outlined in the Summary of Coverage and policy.
- Routine physical exams or tests that do not directly treat an actual illness, injury or condition, including those required by employment or government authority.
- Charges by a provider for telephone consultations.
- Items furnished primarily for the member's personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for hygiene or beautification, etc.).
- Educational services, except as specifically provided or arranged by Anthem Blue Cross and Blue Shield.
- Nutritional counseling or food supplements, except as specifically stated in the Summary of Coverage and policy.
- Durable medical equipment.
- Any services received if they are related to a pre-existing condition as stated in the Summary of Coverage and policy.
- Physical and/or occupational therapy/medicine and/or acupuncture/acupressure, except when provided during an inpatient hospital confinement or as specifically stated in the Summary of Coverage and policy.

- Infusion therapy and any associated supplies, drugs or professional services.
- Smoking cessation programs and medications.
- Foreign country provider charges, except as specifically stated in the Summary of Coverage and policy.
- Growth hormone treatment.
- Routine foot care.
- Charges for which we are unable to determine our liability because the member failed, within 60 days, or as soon as reasonably possible to: (a) authorize us to receive all the medical records and information we requested or; (b) provide us with information we requested regarding the circumstances of the claim or other insurance coverage.
- Organ and tissue transplants, except as specifically stated in the Summary of Coverage and policy.
- Charges for animal to human organ transplants.
- Charges for pregnancy or maternity care, including normal delivery, elective abortion and cesarean section delivery.
- Removal or treatment of hernia, except for strangulated or incarcerated hernia.
- Treatment of varicose veins.

Important Information About HIPAA

Coverage under this short-term plan may make a person ineligible for HIPAA guaranteed issue coverage. To be eligible for a guaranteed issue plan, a person must, among other things, have been most recently covered under an employer-sponsored health care benefits plan. This short-term plan is not an employer-sponsored health care benefits plan.

Additional Information

Please contact your authorized agent for information about other Anthem Blue Cross and Blue Shield coverage options. Approved and enrolled members will receive a health plan ID card with a Summary of Coverage and policy.

The Summary of Coverage and policy provide a comprehensive description of what is covered and what is not covered. You may request a copy of the Summary of Coverage and policy in advance by calling Anthem Blue Cross and Blue Shield toll free at 888-231-5046.

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Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.
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