



The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE: Information about the cost of this **plan** (called the **premium**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/9BZNIND01012024>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 330-1217 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$5,000/person or \$10,000/family for In- <u>Network</u> <u>Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Primary Care. <u>Preventive Care</u> . Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$1,000/person or \$2,000/family for <u>Prescription Drugs</u> for Level 1 Pharmacy- RX Only and In- <u>Network</u> <u>Providers</u> combined. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$6,600/person or \$13,200/family for In- <u>Network</u> <u>Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=GYZ or call (855) 330-1217 for a list of <u>network providers</u> . Costs may	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u>

	vary by site of service and how the <u>provider</u> bills.	for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Not Applicable	Preferred PCP \$5/visit, <u>deductible</u> does not apply PCP \$30/visit, <u>deductible</u> does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	Not Applicable	40% <u>coinsurance</u>	Not covered	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	Not Applicable	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office \$25/visit, <u>deductible</u> does not apply X-Ray – Office \$75/visit, <u>deductible</u> does not apply	Lab – Office Not covered X-Ray – Office Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	50% <u>coinsurance</u>	Not covered	-----none-----
If you need drugs to treat your illness or condition	Typically Generic (Tier 1)	\$25/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and	\$40/prescription, Prescription Drug <u>deductible</u> does not	Not covered (retail and home delivery)	For more information, refer to “Select Drug List” at http://www.anthem.com/pharm

* For more information about limitations and exceptions, see the **plan** or policy document at <https://eoc.anthem.com/eocdps/9BZNIND01012024>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/		\$75/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)	apply (retail only)		acyinformation/ *See Prescription Drug section
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$45/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$135/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)	\$60/prescription, Prescription Drug <u>deductible</u> does not apply (retail only)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail and home delivery)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail only)	Not covered (retail and home delivery)	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail and home delivery)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	40% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	Not Applicable	40% <u>coinsurance</u>	Not covered	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	Not Applicable	\$1,000/visit, then 50% <u>coinsurance</u>	Covered as In- <u>Network</u>	<u>Copayment</u> , <u>coinsurance</u> and <u>deductible</u> waived if admitted.
	<u>Emergency medical transportation</u>	Not Applicable	40% <u>coinsurance</u>	Covered as In- <u>Network</u>	Non-emergency Non- <u>Network</u> Ambulance Services are limited to \$50,000 per occurrence.

* For more information about limitations and exceptions, see the **plan** or policy document at <https://eoc.anthem.com/eocdps/9BZNIND01012024>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	<u>Urgent care</u>	Not Applicable	\$50/visit, <u>deductible</u> does not apply	Covered as In- <u>Network</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	\$950/admission, then 50% <u>coinsurance</u>	Not covered	150 days/benefit period for Inpatient rehabilitation for In- <u>Network Providers</u> .
	Physician/surgeon fees	Not Applicable	40% <u>coinsurance</u>	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Office Visit 40% <u>coinsurance</u> Other Outpatient 40% <u>coinsurance</u>	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Not Applicable	\$950/admission, then 50% <u>coinsurance</u>	Not covered	-----none-----
If you are pregnant	Office visits	Not Applicable	40% <u>coinsurance</u>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Not Applicable	40% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	Not Applicable	\$950/admission, then 50% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Applicable	40% <u>coinsurance</u>	Not covered	-----none-----
	<u>Rehabilitation services</u>	Not Applicable	40% <u>coinsurance</u>	Not covered	*See Therapy Services section.
	<u>Habilitation services</u>	Not Applicable	40% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	Not Applicable	40% <u>coinsurance</u>	Not covered	150 days/benefit period for skilled nursing services for In- <u>Network Providers</u> .
	<u>Durable medical equipment</u>	Not Applicable	40% <u>coinsurance</u>	Not covered	*See <u>Durable Medical Equipment</u> Section
	<u>Hospice services</u>	Not Applicable	40% <u>coinsurance</u>	Not covered	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	Not covered	*See Vision Services section
	Children's glasses	Not Applicable	No charge	Not covered	
	Children's dental check-up	Not Applicable	No charge	Not covered	*See Dental Services section

* For more information about limitations and exceptions, see the **plan** or policy document at <https://eoc.anthem.com/eocdps/9BZNIND01012024>.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Dental care (Adult)
- Routine eye care (Adult)
- Acupuncture
- Long-term care
- Routine foot care
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery 1 procedure/5 years
- Private-duty nursing
- Hearing aids 1 item(s) every 3 years
- Spinal Manipulation 50 visits/benefit period
- Infertility treatment 6 procedures/lifetime

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Nevada Division of Insurance, 1818 E. College Pkwy., Suite 103, Carson City, NV 89706, (775) 687-0700, (888) 872-3234, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 10330, Reno, NV 89520

Nevada Division of Insurance, 1818 E. College Pkwy., Suite 103, Carson City, NV 89706, (775) 687-0700, (888) 872-3234

Office of Consumer Health Assistance, Governor's Consumer Health Advocate, 555 East Washington Ave #4800, Las Vegas, NV 89101, (702) 486-3587, (888) 333-1597, [adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](http://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/), cha@govcha.state.nv.us

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	40%
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,660

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	40%
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	40%
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,700
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 330-1217

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 330-1217 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 330-1217.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 330-1217:

Bassa (Bàsɔ̀ Wùdù): M̈ dyi dyi-diè-djé b̈é b̈édjé b̈á céè-djé nià k̈e dyí ní, ɔ m̈ò nì dyí-b̈édjéìn-djé b̈é m̈ k̈é gbo-kpá-kpá k̈é b̈ɔ̈ kp̈ɔ̈ djé m̈ b̈ídjí-wùdùùñ b̈ó pídyi. B̈é m̈ k̈é wuɖu-zìin-nyò d̈ò gbo wùdù k̈e, d̈á (855) 330-1217.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 330-1217 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 330-1217 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 330-1217。

Dinka (Dinka): Na n̄ɔŋ thiēc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin c̄ol (855) 330-1217.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 330-1217.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 330-1217 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 330-1217.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 330-1217.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 330-1217.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 330-1217.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1217.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 330-1217 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 330-1217.

Igbo (Igbo): O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 330-1217.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 330-1217.

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Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 330-1217

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Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
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