



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/9C0UIND01012024>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 711-8949 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,100/person or \$2,200/family for In- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . Vision. For more information see below.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,800/person or \$13,600/family for In- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=GZL">www.anthem.com/find-care/?alphaprefix=GZL</a> or call (855) 711-8949 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the <a href="#">provider</a> bills.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if

you have a [referral](#) before you see the [specialist](#).



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 provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	\$35/visit for the first 2 visits <a href="#">deductible</a> does not apply, then 25% <a href="#">coinsurance</a>	Not covered	All office visit <a href="#">copayments</a> count towards the same 2 visit limit. Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	Not Applicable	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	\$250/service, then 25% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$10/prescription, <a href="#">deductible</a> does not apply (retail) and \$30/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$25/prescription, <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	For more information, refer to "Select Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug section
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$40/prescription, <a href="#">deductible</a> does not apply (retail) and \$120/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$55/prescription, <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9C0UIND01012024>.

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)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	30% <a href="#">coinsurance</a> (retail and home delivery)	45% <a href="#">coinsurance</a> (retail only)	Not covered (retail and home delivery)	
	Typically Preferred <a href="#">Specialty</a> (brand and generic) (Tier 4)	30% <a href="#">coinsurance</a> (retail and home delivery)	45% <a href="#">coinsurance</a> (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	-----none-----
	Physician/surgeon fees	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not Applicable	\$500/visit, then 25% <a href="#">coinsurance</a>	Covered as In-Network	<a href="#">Copayment, coinsurance</a> and <a href="#">deductible</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	Not Applicable	25% <a href="#">coinsurance</a>	Covered as In-Network	Non-emergency non- <a href="#">network</a> Ambulance Services are limited to \$50,000 per occurrence.
	<a href="#">Urgent care</a>	Not Applicable	\$50/visit <a href="#">deductible</a> does not apply	Covered as In-Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	\$1,000/admission, then 25% <a href="#">coinsurance</a>	Not covered	150 days/benefit period for Inpatient rehabilitation for In-Network Providers.
	Physician/surgeon fees	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Office Visit 25% <a href="#">coinsurance</a> Other Outpatient 25% <a href="#">coinsurance</a>	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Not Applicable	\$1,000/admission, then 25% <a href="#">coinsurance</a>	Not covered	-----none-----
If you are pregnant	Office visits	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Not Applicable	25% <a href="#">coinsurance</a>	Not covered	

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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)	
	Childbirth/delivery facility services	Not Applicable	\$1,000/admission, then 25% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not Applicable	25% <u>coinsurance</u>	Not covered	-----none-----
	<a href="#">Rehabilitation services</a>	Not Applicable	25% <u>coinsurance</u>	Not covered	*See Therapy Services section.
	<a href="#">Habilitation services</a>	Not Applicable	25% <u>coinsurance</u>	Not covered	
	<a href="#">Skilled nursing care</a>	Not Applicable	25% <u>coinsurance</u>	Not covered	150 days/benefit period for skilled nursing services for In-Network Providers.
	<a href="#">Durable medical equipment</a>	Not Applicable	25% <u>coinsurance</u>	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	Not Applicable	25% <u>coinsurance</u>	Not covered	
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

#### 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

**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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9C0UIND01012024>.

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](http://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, [dhhs.nv.gov/Programs/CHA/](http://dhhs.nv.gov/Programs/CHA/), [cha@govcha.state.nv.us](mailto: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.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9C0UIND01012024>.

## 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 [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

\$1,100  
25%  
25%  
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**

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,900

#### *What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,070</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

\$1,100  
25%  
25%  
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**

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

\$1,100  
25%  
25%  
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**

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$400

#### *What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,510</b>

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) 711-8949

**Amharic (አማርኛ):** ለአዲስ ሌሎች ማንኛውም ቅያች ካለዋቸው በፈላጊው ቅንቻ እርዳታ እና ይህን መረጃ በለዕስ የሚገኘት መብት አለዋቸው፡፡ አስተርጓሚ ለማናገድ (855) 711-8949 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 711-8949 (855).

**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) 711-8949։

**Bassa (Basa Wùqdù):** M dyi dyi-diè-dè bë bédé bá céè-dè nià ke dyí ní, o mò nì dyí-bèdèin-dè bë mì kék gbo-kpá-kpá kë bë kpë qé mì bídí-wùqdùún bò pídyi. Bé mì kék wuqu-zììn-nyò dò gbo wùqdù ke, qá (855) 711-8949.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা খান জন্য (855) 711-8949 -তে কল করুন।

**Burmese (မြန်မာ):** ဤတရုပ်တတ်မှုနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အကြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားမြန် တစ်ဦးနှင့် စကားမြန်ရန် ဖူး (855) 711-8949 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) 711-8949。

**Dinka (Dinka):** Na nəj thiēec nē ke de yā thorē, ke yin nəj loj bē yi kuony ku wər alēu bē gəer yic yin ne thoj du ke cin wēu tāāuē ke piny. Te kər yin ba jam wēnē ran ye thok geryic, ke yin cəl (855) 711-8949.

**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) 711-8949.

Farsi (فارسی) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 711-8949 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) 711-8949.

**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) 711-8949.

**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) 711-8949.

**Gujarati (ગુજરાતી)**: જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નનો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહત્ત્મિ મેળવવાનો તમને અધકિક છે. દુભાષયા સાથે વાત કરવા માટે, કોણ કરો (855) 711-8949.

**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) 711-8949.

**Hindi (हिंदी)**: अगर आपके पास इस दस्तावेज 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) 711-8949 |

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