



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/9PQ7IND01012024>. 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) 711-8949 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$800/person or \$1,600/family for In- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Primary Care. Specialist Visit . Preventive Care . Certain Prescription Drugs . Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,100/person or \$4,200/family for In- Network Providers .	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.anthem.com/find-care/?alphaprefix=YFI or call (855) 711-8949 for a list of network providers . Costs may vary by site of service and how the provider bills.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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	\$25/visit deductible does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	Specialist visit	Not Applicable	\$80/visit deductible does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	Preventive care / screening /immunization	Not Applicable	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office \$25/visit, deductible does not apply X-Ray – Office \$50/visit, deductible does not apply	Lab – Office Not covered X-Ray – Office Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	\$200/service, then 20% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	\$5/prescription, deductible does not apply (retail) and \$15/prescription, deductible does not apply (home delivery)	\$15/prescription, deductible does not apply (retail only)	Not covered (retail and home delivery)	For more information, refer to "Select Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$30/prescription, deductible does not apply (retail) and \$90/prescription, deductible does not	\$45/prescription, deductible 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/9PQ7IND01012024>.

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)	
		apply (home delivery)			
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	30% coinsurance (retail and home delivery)	45% coinsurance (retail only)	Not covered (retail and home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	40% coinsurance (retail and home delivery)	55% coinsurance (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	20% coinsurance	Not covered	-----none-----
	Physician/surgeon fees	Not Applicable	20% coinsurance	Not covered	-----none-----
If you need immediate medical attention	Emergency room care	Not Applicable	\$100/visit, then 20% coinsurance	Covered as In- Network	Copayment , coinsurance and deductible waived if admitted.
	Emergency medical transportation	Not Applicable	20% coinsurance	Covered as In- Network	Non-emergency non- network Ambulance Services are limited to \$50,000 per occurrence.
	Urgent care	Not Applicable	\$50/visit deductible does not apply	Covered as In- Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	\$250/admission, then 30% coinsurance	Not covered	150 days/benefit period for Inpatient rehabilitation for In- Network Providers .
	Physician/surgeon fees	Not Applicable	20% coinsurance	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Not Applicable	\$250/admission, then 30% coinsurance	Not covered	-----none-----
If you are	Office visits	Not Applicable	20% coinsurance	Not covered	Maternity care may include tests

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9PQ7IND01012024>.

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		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)	
pregnant	Childbirth/delivery professional services	Not Applicable	20% coinsurance	Not covered	and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	Not Applicable	\$250/admission, then 30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	Not Applicable	20% coinsurance	Not covered	-----none-----
	Rehabilitation services	Not Applicable	20% coinsurance	Not covered	*See Therapy Services section.
	Habilitation services	Not Applicable	20% coinsurance	Not covered	
	Skilled nursing care	Not Applicable	20% coinsurance	Not covered	150 days/benefit period for skilled nursing services for In-Network Providers .
	Durable medical equipment	Not Applicable	20% coinsurance	Not covered	*See Durable Medical Equipment Section
	Hospice services	Not Applicable	20% coinsurance	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

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 .)		
<ul style="list-style-type: none"> Abortion (except in cases of rape, incest, or when the life of the mother is endangered) Dental care (Adult) Routine eye care (Adult) 	<ul style="list-style-type: none"> Acupuncture Long-term care Routine foot care 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Bariatric surgery 1 procedure/5 years Private-duty nursing 	<ul style="list-style-type: none"> Hearing aids 1 item(s) every 3 years Spinal Manipulation 50 visits/benefit period 	<ul style="list-style-type: none"> Infertility treatment

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9PQ7IND01012024>.

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, dhhs.nv.gov/Programs/CHA/, 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 plan's overall deductible	\$800
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	30%
■ Other copayment	\$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:

Cost Sharing	
Deductibles	\$800
Copayments	\$500
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,160

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$800
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	30%
■ Other copayment	\$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:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$800
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	30%
■ Other copayment	\$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:

Cost Sharing	
Deductibles	\$800
Copayments	\$300
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

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): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (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 (855) 711-8949.

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 (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄èdjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǒ kpǒ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (855) 711-8949.

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) 711-8949 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (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 nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (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 هزینه‌ای 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 પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ 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 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) 711-8949 ।

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) 711-8949.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 711-8949.

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) 711-8949.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 711-8949.

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) 711-8949

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (855) 711-8949 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ(855) 711-8949 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura (855) 711-8949.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 711-8949 로 문의하십시오.

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