



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/>. 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 (877) 811-3106 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$6,000/member or \$12,000/family for In- <u>Network Providers</u> . \$12,000/member or \$24,000/family for <u>Out-of-Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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>Specialist Visit</u> . <u>Preventive Care</u> . For more information see below.	This <u>plan</u> 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 <u>plan</u> 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. \$200/member or \$400/family for <u>Prescription Drugs</u> for <u>Preferred</u> and In- <u>Network Providers</u> combined. \$200/member or \$400/family for <u>Prescription Drugs</u> for <u>Out-of-Network Providers</u> . 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 <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$7,500/member or \$15,000/family for In- <u>Network Providers</u> . \$22,500/member or \$45,000/family for <u>Out-of-Network 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 <u>plan</u> , 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>Pre-Authorization</u> Penalties, <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> 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 <u>network provider</u>?	Yes. See www.anthem.com/find-care/?alphaprefix=YFW or call (877) 811-3106 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> 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>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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)	Out-of-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	Same as In- <u>Network</u>	\$30/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	Same as In- <u>Network</u>	\$60/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	Same as In- <u>Network</u>	No charge	50% <u>coinsurance</u>	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 Same as In- <u>Network</u> X-Ray – Office Same as In- <u>Network</u>	Lab – Office No charge X-Ray – Office \$30/visit, <u>deductible</u> does not apply	Lab – Office 50% <u>coinsurance</u> X-Ray – Office 50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	Same as In- <u>Network</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----

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

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)	Out-of-Network Provider (You will pay the most)	
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)	\$15/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$37.50/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)	\$25/prescription, Prescription Drug <u>deductible</u> does not apply (retail only)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> does not apply (retail) and Not covered (home delivery)	For more information, refer to “Essential Drug List” at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$45/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$112.50/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	\$55/prescription, Prescription Drug <u>deductible</u> applies (retail only)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$75/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$225/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	\$85/prescription, Prescription Drug <u>deductible</u> applies (retail only)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail) and Not covered (home delivery)	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	30% <u>coinsurance</u> up to \$500/prescription, Prescription Drug <u>deductible</u> applies (retail and home delivery)	30% <u>coinsurance</u> up to \$600/prescription, Prescription Drug <u>deductible</u> applies (retail only)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail) and Not covered (home delivery)	

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

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)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	30% <u>coinsurance</u> for Ambulatory Surgical Center for In-Network Providers.
	Physician/surgeon fees	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	Same as In-Network	\$400/visit; then 30% <u>coinsurance</u> , <u>deductible</u> does not apply	Covered as In-Network	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	Same as In-Network	30% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Urgent care</u>	Same as In-Network	\$60/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Other cost shares may apply depending on services provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as In-Network	Office Visit \$30/visit, <u>deductible</u> does not apply Other Outpatient 30% <u>coinsurance</u>	Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	Same as In-Network	\$300/pregnancy, <u>deductible</u> does not apply	50% <u>coinsurance</u>	One <u>copayment</u> per pregnancy for both office visits and childbirth/delivery professional services. Maternity care may include tests and services
	Childbirth/delivery professional services	Same as In-Network	\$300/pregnancy, <u>deductible</u> does not apply	50% <u>coinsurance</u>	

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

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)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	<u>Home health care</u>	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	<u>Rehabilitation services</u>	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<u>Durable medical equipment</u>	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> section.
	<u>Hospice services</u>	Same as In-Network	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

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.)

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| <ul style="list-style-type: none"> • Bariatric surgery • Dental care (Adult) • Hearing aids • <u>Preauthorization</u> - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. Contact us to find out what | <ul style="list-style-type: none"> • Children's dental check-up • Eye exams for a child • Infertility treatment • Routine eye care (Adult) | <ul style="list-style-type: none"> • Cosmetic surgery • Glasses for a child • Long-term care • Routine foot care |
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* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/>.

must be preauthorized and whether preauthorization has been given.

- Weight loss programs

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

- Acupuncture 20 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Spinal Manipulation 20 visits/benefit period

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, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, 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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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

Additionally, a consumer assistance program can help you file your appeal. Contact Nevada Division of Insurance - Las Vegas Office 3300 W. Sahara Ave., Suite 275 Las Vegas, Nevada 89102, Nevada Division of Insurance - Carson City Office 1818 East College Parkway, Suite 103 Carson City, Nevada 89706, (888) 872-3234, <http://doi.nv.gov/Consumers/>

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? Yes.

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>	\$6,000
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	0%

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>	\$6,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,160

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>	\$6,000
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	0%

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>	\$200
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	0%

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>	\$1,600
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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 (877) 811-3106

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 811-3106 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 (877) 811-3106.

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՝ (877) 811-3106:

Bassa (Bàsɔ̀ Wùdù): M̐ dyi dyi-diè-djé bɛ́ bédjé bá céè-djé nià kɛ dyí ní, ɔ̀ m̀b̀ nì dyí-bédjéìn-djé bɛ́ m̀ kɛ gbo-kpá-kpá kè bɔ́ kpɔ́ djé m̀ bídí-wùdùùn b́ó pídýi. Bɛ́ m̀ kɛ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́á (877) 811-3106.

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 (877) 811-3106 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (877) 811-3106 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(877) 811-3106。

Dinka (Dinka): Na naŋ thiëc në ke de yā thorë, ke yin naŋ loŋ bē yi kuony ku wër alëu bē gëer yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kōr yin ba jam wënë ran ye thok geryic, ke yin cōl (877) 811-3106.

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 (877) 811-3106.

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 (877) 811-3106 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 (877) 811-3106.

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 (877) 811-3106.

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 (877) 811-3106.

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 (877) 811-3106.

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Language Access Services:

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