



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 see www.lucenthealth.com/capitol or call 1-800-331-5301. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-331-5301 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers \$1,500 individual / \$3,000 family Out-of-network providers \$3,000 individual / \$6,000 family	Generally, you must pay all 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 deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care and services with a copay may be covered before you meet your deductible .	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?	Yes. \$500 for failure to obtain hospital preauthorization . Dental \$50 individual / \$100 family.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers \$2,900 individual / \$5,800 family Out-of-network providers \$5,800 individual / \$11,600 family	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 must 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, penalties, 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 or call 1-877-789-8488 for a list of network providers	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 a specialist you choose without permission for this plan .

 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
		Network Provider (You will pay the least)	Out-of-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	\$30 copay /visit; deductible does not apply	30% coinsurance	None
	Specialist visit	\$30 copay /visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening /immunization	No charge; deductible does not apply	No charge, deductible does not apply	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$25 copay /visit; deductible does not apply	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$100 copay /visit; deductible does not apply	30% coinsurance	Preauthorization is required or plan payment reduced by 50%
If you need drugs to treat your illness or condition More information about	Generic drugs	Retail: \$20 copay /prescription Kroger Retail: \$30 copay /prescription Mail Order: \$30	Not Covered	Deductible does not apply. Retail: Covers up to a 34-day supply

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.lucenthealth.com/capitol

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at www.kpp-rx.com		copay /prescription		Kroger Retail: Covers up to a 90-day supply Mail Order: Covers up to a 34-90 day supply
	Preferred brand drugs	Retail: \$35 copay /prescription Kroger Retail: \$60 copay /prescription Mail Order: \$60 copay /prescription	Not Covered	Specialty drugs : Covers up to a 30-day supply
	Non-preferred brand drugs	Retail: \$55 copay /prescription Kroger Retail: \$100 copay /prescription Mail Order: \$100 copay /prescription	Not Covered	Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.
	Specialty drugs	Generic: \$60 copay /prescription Preferred Brand: \$110 copay /prescription Non-Formulary Brand: \$160 copay /prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	In network deductible applies to Out-of-Network services.
	Emergency medical transportation	\$250 copay /trip; deductible does not apply	30% coinsurance	Air and/or ground
	Urgent care	\$50 copay /visit; deductible does not apply	30% coinsurance	None
If you have a hospital	Facility fee (e.g., hospital)	10% coinsurance	\$2,500 copay /	Preauthorization is required. If you don't

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay	room)		admission and 30% coinsurance	get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit; deductible does not apply	30% coinsurance	None
	Inpatient services	10% coinsurance	\$2,500 copay /admission and 30% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	\$30 copay /initial office visit	30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance , and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for dependent children. Preauthorization may be required.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	None
	Rehabilitation services	10% coinsurance	30% coinsurance	None
	Habilitation services			
	Skilled nursing care	10% coinsurance ; deductible does not apply	30% coinsurance ; deductible does not apply	Limited to 90 days per calendar year
	Durable medical equipment	10% coinsurance	30% coinsurance	Rental not to exceed purchase price
	Hospice services	10% coinsurance	30% coinsurance	Includes family bereavement counseling (\$500 calendar year maximum)
If your child needs	Children's eye exam	Not Covered	Not Covered	Routine screenings covered as defined

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care				under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	No charge; deductible does not apply	No charge; deductible does not apply	Limited to two exams per year and \$1,500 per calendar year under the dental benefits. Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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 .)		
- Bariatric Surgery - Cosmetic Surgery - Hearing Aids - Infertility Treatment	- Long Term Care - Non-emergency care when traveling outside the U.S. - Private Duty Nursing	- Routine Eye Care (Adult) - Routine Foot Care - Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Acupuncture (\$1,500 per calendar year)	Chiropractic Care	

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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: the plan at Nye County School District c/o Lucent Health Solutions, LLC at 10951 White Rock Road – Suite 100, Rancho Cordova, CA 95670 or call 1-800-331-5301. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-331-5301

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-5301

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-331-5301

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-331-5301

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	\$1,500
■ Specialist copayments	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$1,500
Copayments	\$400
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist copayments	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$1,000
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist copayments	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$1,400
Copayments	\$500
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,940

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.