
 **Oka**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, [insert contact information]. 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 1-800-863-7515 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network: Individual/Family \$3,300 / \$6,600 Out-of-Network: Individual/Family \$6,600 / \$13,200	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. Preventive care and primary care services are covered before you meet your deductible.	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 coinsurance may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive</a> services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> 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 do not have to meet the <a href="#">deductible</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-Network: Individual/Family \$4,000 / \$8,000 Out-of-Network: Individual/Family \$8,000 / \$16,000	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>	<a href="#">Premiums</a> , <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.prominencehealthplan.com">www.prominencehealthplan.com</a> or call 1-800-863-7515 for a list of <a href="#">network providers</a> .	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 charge</a> 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>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		PPO Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	<u>Primary Care Provider (PCP)</u> and <u>Specialist copay</u> applies to all services in the Practitioner's office unless the service is also listed on this Summary of Benefits with an additional <u>copay</u> .  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay.
	<a href="#">Specialist</a> visit	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	CYD/30% coinsurance per visit	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	CYD/0% coinsurance per test  Blood work (Laboratory) – CYD/0% coinsurance per visit	CYD/30% coinsurance per test  CYD/30% coinsurance per test	Some invasive diagnostic procedures are treated as outpatient hospital visits.  Calendar Year <u>Deductible</u> (CYD)
	Imaging (CT/PET scans, MRIs)	CYD/0% coinsurance per test	CYD/30% coinsurance per test	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.prominencehealthplan.com">prescription drug coverage</a> is available at <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a></p>	Generic drugs	CYD/\$15 copay per prescription (retail)	Not Covered	<p><u>Copay</u> applies to 30 day fills for preferred generic drugs. 90 day fills of preferred generic maintenance medications at retail or mail order are paid at 2 <u>copays</u>. Prior authorization (PA) requirements may apply. Visit the formulary on <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a>. If PA is not obtained; you will be responsible for the full cost of your prescription at the pharmacy. You may fill your prescription, but your <u>copay</u> will not apply.</p>
	Preferred brand drugs	CYD/\$40 copay per prescription (retail)	Not Covered	
	Non-preferred brand drugs	CYD/\$60 copay per prescription (retail)	Not Covered	<p>Copay applies to 30 day fills. 90 day fills of nonpreferred name brand medications at retail or mail order are paid at 3 copays. Prior authorization (PA) requirements may apply. Visit the formulary on <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a>. If PA is not obtained; you will be responsible for the full cost of your prescription at the pharmacy. You may fill your prescription, but your copay will not apply.</p>
	<a href="#">Specialty drugs</a>	CYD/20% coinsurance per prescription	Not Covered	<p>Limit becomes maximum out-of-pocket. Prior authorization (PA) requirements may apply. Visit the formulary on <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a>. If PA is not obtained; you will be responsible for the full cost of your prescription at the pharmacy. You may fill your prescription, but your <u>copay</u> will not apply.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	CYD/0% coinsurance per surgery	CYD/30% coinsurance per surgery	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained, claims subject to denial.
	Physician/surgeon fees	CYD/0% coinsurance per surgery	CYD/30% coinsurance per surgery	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	CYD/0% coinsurance per visit	CYD/0% coinsurance per visit	The <u>copay</u> is waived when the member is admitted as an inpatient directly from the emergency room.
	<a href="#">Emergency medical transportation</a>	CYD/0% coinsurance per trip	CYD/0% coinsurance per trip	Prior authorization (PA) required for non-emergency transportation. Prior authorization (PA) required for air ambulance. If PA is not obtained; <u>claims</u> subject to denial.
	<a href="#">Urgent care</a>	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	In and Out-of-Area <u>Urgent Care</u> Services are covered for <u>Medically Necessary</u> Covered Services. Members should call 1-800-863-7515 for assistance prior to obtaining Out-of-Area <u>Urgent Care</u> Services.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	Physician/surgeon fees	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	Inpatient services	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	<p><u>Copay</u> applies to all Obstetrician services associated with the birth. <u>Cost Sharing</u> does not apply to <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Ancillary maternity charges including but not limited to fetal non-stress tests and amniocentesis will require an additional member share of cost.</p>
	Childbirth/delivery professional services	CYD/0% coinsurance per delivery	CYD/30% coinsurance per delivery	
	Childbirth/delivery facility services	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	Limited to <u>30</u> visits per calendar year. Prior authorization (PA) requirements apply. If PA is not obtained; <u>claims</u> subject to denial.
	<a href="#">Rehabilitation services</a>	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	Limited to <u>60</u> visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization (PA) requirements apply. If PA is not obtained; <u>claims</u> subject to denial.
	<a href="#">Habilitation services</a>	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	Limited to <u>100</u> days per calendar year. Prior authorization (PA) requirements apply. If PA is not obtained; <u>claims</u> subject to denial.
	<a href="#">Skilled nursing care</a>	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	Limited to <u>100</u> days per calendar year. Prior authorization (PA) requirements apply. If PA is not obtained; <u>claims</u> subject to denial.
	<a href="#">Durable medical equipment</a>	CYD/0% coinsurance per device	CYD/30% coinsurance per device	Prior authorization (PA) requirements apply. If PA is not obtained; <u>claims</u> subject to denial. Excludes vehicle modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	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](#).)

- Abortion with the exception of limited services
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs
- Hearing aids-limited to one pair every three years

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Routine foot 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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: Prominence Health Plan at 1-800-863-7515 or visit [www.prominencehealthplan.com](http://www.prominencehealthplan.com). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Nevada Division of Insurance at 1-888-872-3234.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 1-800-863-7515.

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

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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](#) Insrt
- [Specialist](#) copay/coinsurance Insrt
- Hospital (facility) copay/coinsurance Insrt
- Other: coinsurance Insrt

**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*)

<b>Total Example Cost</b>	<b>\$ Insrt</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$Insrt
Copayments	\$Insrt
Coinsurance	\$Insrt
<i>What isn't covered</i>	
Limits or exclusions	\$Insrt
<b>The total Peg would pay is</b>	<b>\$ Insrt</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

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

**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*)

<b>Total Example Cost</b>	<b>\$ Insrt</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$Insrt
Copayments	\$Insrt
Coinsurance	\$Insrt
<i>What isn't covered</i>	
Limits or exclusions	\$Insrt
<b>The total Joe would pay is</b>	<b>\$ Insrt</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

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

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$ Insrt</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$Insrt
Copayments	\$Insrt
Coinsurance	\$Insrt
<i>What isn't covered</i>	
Limits or exclusions	\$Insrt
<b>The total Mia would pay is</b>	<b>\$ Insrt</b>