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:
What is the overall deductible?	In-Network: Individual/Family $500 / $1,000 Out-of-Network: Individual/Family $2,000 / $4,000	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. Preventive care and primary care services are 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?	No.	You do not have to meet the deductible for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual/Family $3,000 / $6,000 Out-of-Network: Individual/Family $6,000 / $12,000	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.prominencehealthplan.com or call 1-800-863-7515 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 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
		PPO 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	$15 copay per visit	CYD/30% coinsurance per visit	Primary Care Provider (PCP) and Specialist copay applies to all services in the Practitioner's office unless the service is also listed on this Summary of Benefits with an additional copay.
	Specialist visit	$30 copay per visit	CYD/30% coinsurance per visit	
	Preventive care/screening/ immunization	No Charge	CYD/30% coinsurance per visit	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.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay per test Blood work (Laboratory) – $0 copay per test	CYD/30% coinsurance per test CYD/30% coinsurance per test	Some invasive diagnostic procedures are treated as outpatient hospital visits.
	Imaging (CT/PET scans, MRIs)	$100 copay per test	CYD/30% coinsurance per test	Calendar Year Deductible (CYD)

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.prominencehealthplan.com	Generic drugs	$10 copay per prescription (retail)	Not Covered	Copay 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 copays. Prior authorization (PA) requirements may apply. Visit the formulary on www.prominencehealthplan.com. 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.
	Preferred brand drugs	$30 copay per prescription (retail)	Not Covered	
	Non-preferred brand drugs	$50 copay per prescription (retail)	Not Covered	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 www.prominencehealthplan.com. 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.
	Specialty drugs	20% coinsurance per prescription	Not Covered	Limit becomes maximum out-of-pocket. Prior authorization (PA) requirements may apply. Visit the formulary on www.prominencehealthplan.com. 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.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	CYD/10% coinsurance per surgery	CYD/30% coinsurance per surgery	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained, claims subject to denial.
	Physician/surgeon fees	CYD/10% coinsurance per surgery	CYD/30% coinsurance per surgery	
If you need immediate medical attention	Emergency room care	$100 copay per visit	$100 copay per visit	The copay is waived when the member is admitted as an inpatient directly from the emergency room.
	Emergency medical transportation	$200 copay per trip – Air $100 copay per trip -- ground	$200 copay per trip – Air $100 copay per trip -- ground	Prior authorization (PA) required for non-emergency transportation. Prior authorization (PA) required for air ambulance. If PA is not obtained; claims subject to denial.
	Urgent care	$35 copay per visit	CYD/30% coinsurance per visit	In and Out-of-Area Urgent Care Services are covered for Medically Necessary Covered Services. Members should call 1-800-863-7515 for assistance prior to obtaining Out-of-Area Urgent Care Services.
If you have a hospital stay	Facility fee (e.g., hospital room)	CYD/10% coinsurance per admit	CYD/30% coinsurance per admit	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Physician/surgeon fees	CYD/10% coinsurance per admit	CYD/30% coinsurance per surgery	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay	CYD/30% coinsurance per visit	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Inpatient services	CYD/10% coinsurance per admit	CYD/30% coinsurance per admit	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims 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	$30 copay per visit	CYD/30% coinsurance per visit	Copay applies to all Obstetrician services associated with the birth. Cost Sharing does not apply to preventive services. Depending on the type of services, a copayment or deductible 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.
	Childbirth/delivery professional services	$30 copay per visit	CYD/30% coinsurance per delivery	
	Childbirth/delivery facility services	CYD/10% coinsurance per admit	CYD/30% coinsurance per admit	
If you need help recovering or have other special health needs	Home health care	CYD/10% coinsurance per visit	CYD/30% coinsurance per visit	Limited to 30 visits per calendar year. Prior authorization (PA) requirements apply. If PA is not obtained; claims subject to denial.
	Rehabilitation services	$15 copay per visit	CYD/30% coinsurance per visit	Limited to 60 visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization (PA) requirements apply. If PA is not obtained; claims subject to denial.
	Habilitation services	$15 copay per visit	CYD/30% coinsurance per visit	
	Skilled nursing care	CYD/10% coinsurance per visit	CYD/30% coinsurance per visit	Limited to 100 days per calendar year. Prior authorization (PA) requirements apply. If PA is not obtained; claims subject to denial.
	Durable medical equipment	CYD/10% coinsurance per device	CYD/30% coinsurance per device	Prior authorization (PA) requirements apply. If PA is not obtained; claims subject to denial. Excludes vehicle modifications, exercise, and bathroom equipment.
	Hospice services	$30 copay 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 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. 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 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.

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)*

Total Example Cost	**$ Insrt**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$Insrt
Copayments	$Insrt
Coinsurance	$Insrt
What isn't covered	
Limits or exclusions	$Insrt
The total Peg would pay is	**$ Insrt**

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)*

Total Example Cost	**$ Insrt**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$Insrt
Copayments	$Insrt
Coinsurance	$Insrt
What isn't covered	
Limits or exclusions	$Insrt
The total Joe would pay is	**$ Insrt**

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)*

Total Example Cost	**$ Insrt**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$Insrt
Copayments	$Insrt
Coinsurance	$Insrt
What isn't covered	
Limits or exclusions	$Insrt
The total Mia would pay is	**$ Insrt**