This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.prominencehealthplan.com or by calling **1-800-863-7515**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network: $1,500** Individual / 3x family **Out-of-Network**: **NA** Individual / 3x family	For specified services, you must pay all the costs up to the **deductible** amount before the plan begins to pay for those covered services. All **deductibles** are based on a Calendar year.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**In-Network: $6,000** Individual / 2x family **Out-of-Network: NA** Individual / 2x family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, excluded charges.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	See the chart on the following pages which describe any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. For a list of preferred **providers**, see **www.prominencehealthplan.com** or call 1-800-863-7515.	If you use an in-**network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-**network** doctor or hospital may use an out-of-**network** provider for some services. Under an HMO plan, the use of out-of-**network** or non-preferred **providers** is limited to emergency services only.
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. A list of **specialists** that require a referral can be found on the prior authorization requirement list found at www.prominencehealthplan.com.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.prominencehealthplan.com or call 1-800-863-7515 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay per visit	Not Covered	None
	Specialist visit	$60 copay per visit	Not Covered	None
	Other practitioner office visit	$60 copay per visit	Not Covered	None
	FDA approved, generic oral contraception medication.	No Charge	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	None

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	In-Network, freestanding facility for x-ray or basic diagnostic tests $50 copay per test Hospital outpatient facility for x-ray. or basic diagnostic tests $150 copay per test Blood work (Laboratory) $0 for blood work	Not Covered	Deductible applies to procedures performed in hospital outpatient facilities. The use of a non-hospital outpatient facility will result in a much lower cost to members.
	Imaging (CT/PET scans, MRIs)	In-Network, freestanding facility for CT/MRI scans $100 copay per test In-Network, freestanding facility for PET Scans $200 copay per test Hospital outpatient facility CT/MRIs scans $250 copay per test Hospital outpatient facility PET Scans $500 copay per trip	Not Covered	Deductible applies to procedures performed in hospital outpatient facilities. The use of a non-hospital outpatient facility will result in a much lower cost to members.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. **More information about prescription drug coverage is available at www.prominencehealthplan.com**	Generic drugs	$15 copay per prescription (retail or mail order)	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.
	Preferred brand drugs	$40 copay per prescription (retail or mail order)	Not Covered	Copay applies to 30 day fills. 90 day fills of preferred name brand maintenance medications at retail or mail order are paid at 2 copays.
	Non-preferred brand drugs	$60 copay per prescription (retail or mail order)	Not Covered	Copay applies to 30 day fills. 90 day fills of non-preferred name brand medications at retail or mail order are paid at 3 copays.
	Specialty drugs	20% coinsurance	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay per admit	Not Covered	
	Physician/surgeon fees	$0 copay	Not Covered	Physician fee included in the in-**network**, outpatient facility copay.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	Medically Necessary Only
	Emergency medical transportation	Ground: $200 copay per trip Air: $200 copay per trip	Ground: $200 copay per trip Air: $200 copay per trip	Medically Necessary Only
	Urgent care	$50 copay per visit	Not Covered	Covered "In-Network" only. Refer to your EOC for your out-of-service area emergency benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay per admit	Not Covered	Copay applies after calendar year **deductible.** Copay includes surgeon, facility and anesthesia charges.
	Physician/surgeon fee	$0 copay per procedure	Not Covered	Physician fee included in the in-**network**, inpatient facility copay.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit or $500 copay per program	Not Covered	
	Mental/Behavioral health inpatient services	$1,500 copay per admit	Not Covered	Copay applies after calendar year **deductible.**
	Substance use disorder outpatient services	$40 copay per visit or $500 copay per program	Not Covered	
	Substance use disorder inpatient services	$1,500 copay per admit	Not Covered	Copay applies after calendar year **deductible.**

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$200 copay per Pregnancy	Not Covered	Copay includes all physician costs for prenatal, labor and delivery, and one postnatal visit. Additional testing could result in a greater share of cost.
	Delivery and all inpatient services	$1,500 copay per admit	Not Covered	Copay applies after calendar year **deductible**.
If you need help recovering or have other special health needs	Home health care	$40 copay per visit	Not Covered	Maximum of 30 visits per calendar year, in **network** and out of **network** combined
	Rehabilitation services	$60 copay per visit	Not Covered	60 visits per condition per calendar year These services includes Physical Therapy, Occupational Therapy and Speech.
	Habilitation services	$60 copay per visit	Not Covered	Limited to 200 visits, per calendar year, for Autism
	Skilled nursing care	$1,500 copay per admit	Not Covered	Copay applies after calendar year **deductible**. 100 days per calendar year.
	Durable medical equipment	$50 copay per month or $100 copay per purchase	Not Covered	Copay applies after calendar year **deductible**.
	Hospice service	No Charge per visit	Not Covered	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic Surgery	• Residential Treatment	• Long Term Care
• Dental care (Adult)	• Routine Eye Care (Adult)	• Infertility treatment

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture	• Spinal Manipulation	• Bariatric Surgery

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue may also apply. For more information on your rights to continue coverage, contact the plan at 775-770-9310 or 1-800-863-7515. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www. cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Secretary to the Consumer Health Assistance. You must submit your complaint in writing to: Consumer Health Assistance 555 East Washington Avenue, Suite 4800 Las Vegas, Nevada 89101 t: (702) 486-3587 or t:(888) 333-1597 f: (702) 486-3586 Web: **www.govcha.nv.gov**. You may also call the Nevada Division of Insurance, 1818 East College Pkwy., Suite 103, Carson City, Nevada 89706 t (775) 687-0700 f: (775) 687-0787 Web: **www.doi.nv.gov** or e-mail: **insinfo@doi.state.nv.us**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actual value). This health coverage does meet the minimum value standard for the benefits it provides.

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 page

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:**$7,540
- **Plan pays $5,400**
- **Patient pays $2,140**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$1,000
Copays	$990
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,140**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:**$5,400
- **Plan pays $3,260**
- **Patient pays $2,140**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures)	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$1,000
Copays	$1,060
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,140**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.