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:** HMO: $1,500 Individual, 3x family PPO: $3,500 Individual, 3x Family **Out-of-Network:** $4,500 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:** HMO: $6,000 Individual, 2x family **PPO:** $6,350 Individual, 2x Family **Out-of-Network:** $9,000 Individual, 2x Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one 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 charts on the following pages which describes any limits on what the plan will pay for *specific* covered services, such as office visits.
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?	Physician to physician referrals are not required.	Although referrals are not required, some specialist and services require prior authorization
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**.

- **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 **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	HMO: $30 copay per visit	PPO: $40 copay per visit	50% coinsurance after deductible	
	Specialist visit	$50 copay per visit	$60 copay per visit	50% coinsurance after deductible	
	Other practitioner office visit	$50 copay per visit	$60 copay per visit	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
	FDA approved, generic oral contraception medication.	No charge	No charge	30% coinsurance after deductible	None
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to PPO In and Out-of-Network services.

Common Medical Event	Services You May Need	Your Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	In Network, free-standing, facility for X-ray or basic diagnostic test $50 copay per test Hospital outpatient facility for X-ray or basic diagnostic test $250 copay per test **Bloodwork** (Laboratory) no copay for blood work.	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to hospital outpatient facility. The use of a non-hospital outpatient facility will result in a much lower cost to member.
	Imaging (CT/PET scans, MRIs)	In Network, free-standing, facility for CT / MRI scans $100 per test In Network, free-standing, facility for PET scans $200 per Hospital outpatient facility for CT / MRI scans $500 copay per test Hospital outpatient facility for PET Scans $1,000 copay per test	30% coinsurance deductible	50% coinsurance after deductible	Deductible applies to hospital outpatient facility. High-tech imaging require prior-authorization. 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 Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$15 copay per prescription (retail or mail order)	$15 copay per prescription (retail or mail order)	30% coinsurance after deductible	Copay applies to 30 day fills. Generic maintenance medications at retail or mail order are paid at 2 copays for a 90 day supply.
	Preferred brand drugs	$40 copay per prescription (retail or mail order)	$40 copay per prescription (retail or mail order)	30% coinsurance after deductible	Copay applies to 30 day fills. Preferred name brand maintenance medications at retail or mail order are paid at 2 copays for a 90 day supply.
	Non-preferred brand drugs	$60 copay per prescription (retail or mail order)	$60 copay per prescription (retail or mail order)	30% coinsurance after deductible	Copay applies to 30 day fills. Non-Preferred brand maintenance medications at retail or mail order are paid at 3 copays for a 90 day supply.
	Specialty drugs	20% coinsurance	20% coinsurance	30% coinsurance after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$400 copay per admit	30% coinsurance after deductible	50% coinsurance after deductible	
	Physician/surgeon fees	Included in facility copay	30% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	$150 copay per visit	Medically Necessary Only.
	Emergency medical transportation	Air: $200 copay per trip. Ground: $200 copay per trip.	Air: $200 copay per trip. Ground: $200 copay per trip.	Air: $200 copay per trip. Ground: $200 copay per trip.	Medically Necessary Only.
	Urgent care	$50 copay per visit	$50 copay per visit	$50 copay per visit	In and Out-of-Area Urgent Care Services are covered for Medically Necessary Covered Services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admit	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to In and Out-of-Network
	Physician/surgeon fee	$0 copay	30% coinsurance after deductible	50% coinsurance after deductible	All inpatient, HMO, physician fees included in the inpatient copay.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit or $400 copay per program	30% coinsurance after deductible	50% coinsurance after deductible	
	Mental/Behavioral health inpatient services	$1,000 copay per admit	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to In and Out-of-Network
	Substance use disorder outpatient services	$30 copay per visit or $400 copay per program.	30% coinsurance after deductible	50% coinsurance after deductible	
	Substance use disorder inpatient services	$1,000 copay per admit	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to In and Out-of-Network

Common Medical Event	Services You May Need	Your Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$200 copay per pregnancy	$300 copay per visit	50% coinsurance after deductible	Well woman prenatal visits are covered without cost share. Copay includes all physician costs for prenatal, labor and delivery, and one postnatal visit. Some additional testing will result inmore share of cost.
	Delivery and all inpatient services	$1,000 copay per admit	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to In and Out-of-Network.

Common Medical Event	Services You May Need	Your Costs if You Use An HMO Network Provider Tier 1	Your Cost If You Use An In-Network PPO Provider Tier 2	Your Cost If You Use An Out-of-Network Provider Tier 3	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$30 copay per visit PCP $50 copay per visit specialist	Covered under HMO only	Covered under HMO only	Limited to 30 visits per calendar year.
	Rehabilitation services	$50 copay per visit	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 visits per condition, per calendar year.
	Habilitation services	$50 copay per visit	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 200 visits per calendar year for Autism.
	Skilled nursing care	$1,000 copay per admit	Covered under HMO only	Covered under HMO only	100 days per calendar year limit. Deductible applies to In-network.
	Durable medical equipment	$50 per rental or $100 per purchase	30% coinsurance after deductible	50% coinsurance after deductible	Deductible applies to In and Out-of-Network.
	Hospice service	No Charge	30% coinsurance after deductible	50% coinsurance after deductible	
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	None
	Glasses	Not covered	Not covered	Not covered	None
	Dental check-up	Not covered	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
- Dental Care (Adult)
- Residential Treatment
- Routine Eye Care (Adult)
- Long Term Care
- 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 1-800-863-7515 or 775-770-9310. 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.

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 Divison of Insurance, 1818 East College Pkwy., Suite 103, Carson City, Nevada 89706 t. t (775) 687-0700 f: (775_ 687-0787 Web: www.doi.nv.gov or e-mail: insinfo@doi.state.nv.us.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, 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** $6,650
- **Patient pays** $890

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	$0
Copays	$740
Coinsurance	$00
Limits or exclusions	$150
Total	**$890**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,250
- **Patient pays** $1,550

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	$0
Copays	$1,070
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,550**

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.