

**SUMMARY OF BENEFITS
PROMINENCE PREFERRED HEALTH INSURANCE
LARGE GROUP EMPLOYER PLAN**

CARSON CITY SCHOOL DISTRICT PPO HD

This disclosure statement provides only a brief description of some important features and limitations of your policy. The Certificate of Coverage (COC) sets forth in detail the rights and obligations of both you and the insurance company. It is important you review the COC once you are enrolled.

If you have questions about this summary of benefits (SOB), please call Prominence Health Plan Customer Service at 800-863-7515 or TTY Operator Assistance at 800-326-6868. Our website, www.prominencehealthplan.com, also serves as an important resource and includes information about provider directories, urgent care and emergency care locations and more

**CALENDAR YEAR DEDUCTIBLE (CYD)
ANNUAL OUT-OF-POCKET MAXIMUMS (OOPM)**

CALENDAR YEAR DEDUCTIBLE	IN-NETWORK¹: Member pays \$3,400 single; \$6,800 family OUT-OF-NETWORK^{1a}: Member pays \$6,800 single; \$13,600 family
<p>A deductible is a set amount of covered charges occurring each calendar year which must be paid by the member before benefits are payable under this plan. Copays do not count towards the deductible.</p> <p>This High Deductible Health Plan Includes an embedded individual deductible provision. An embedded individual deductible combines individual and family deductibles in a family health insurance policy. The plan will begin to pay benefits as soon as one member of the family reaches the individual deductible limit.</p>	
ANNUAL OUT-OF-POCKET MAXIMUM	IN-NETWORK¹: Member pays \$3,400 single; \$6,800 family OUT-OF-NETWORK^{1a}: Member pays \$6,800 single; \$13,600 family
<p>Deductibles, coinsurance and copays all accrue toward the out-of-pocket maximum (OOPM). Use of the emergency room for non-emergency conditions cannot be used to satisfy the OOPM.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> • expenses which are not covered by the Plan, for any reason; • expenses in excess of Usual and Customary; and • expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program. 	
COINSURANCE	IN-NETWORK¹: 0% coinsurance OUT-OF-NETWORK^{1a}: 30% coinsurance

¹ When travelling or living outside the Prominence UHN service areas, you are eligible to receive medical care by a Cigna PPO Network Provider under your In-Network benefits. To find a Cigna Provider, please visit www.myCigna.com ^{1a} Members who obtain covered benefits from non-plan provider will be responsible for all charges in excess of the Usual and Customary Rate (UCR) charge and you could be responsible for all expenses over and above the UCR. Those charges in excess of the UCR will not be applied to the out-of-pocket maximum. UCR services mean the maximum amount the plan will pay for a covered service.

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**CARSON CITY SCHOOL DISTRICT PPO HD
SUMMARY OF BENEFITS - COPAYS**

TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE PPO IN-NETWORK ¹	YOUR OUT-OF-POCKET EXPENSE PPO OUT-OF-NETWORK ^{1a}
<p>Provider Office Visits</p> <ul style="list-style-type: none"> • Priority Care visit • Primary care provider (PCP) office & telemedicine visit • Specialist office & telemedicine visit <p><i>Charges in addition to the office visit copay may include</i></p> <ul style="list-style-type: none"> • In-office surgical procedure • In-office injectable (excluding specialty drugs) <p><i>There may be additional changes for other services in the provider's office. See this summary of benefits for details.</i></p>	<p>CYD/0% coinsurance CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance CYD/0% coinsurance</p>	<p>CYD/30% coinsurance CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance CYD/30% coinsurance</p>
<p>Teladoc telemedicine</p> <ul style="list-style-type: none"> • Primary care • Mental Health 	<p>0% coinsurance 0% coinsurance</p>	<p>Not applicable Not applicable</p>
<p>Alternative Medicine Homeopathy, acupuncture and integrated medicine. \$1,500 maximum per calendar year.</p>	<p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p>
<p>Ambulance Services – Medically necessary only</p> <ul style="list-style-type: none"> • Air Ambulance • Ground Ambulance 	<p>CYD/0% coinsurance CYD/0% coinsurance</p>	
<p>Durable Medical Equipment – Rental or purchase Covered when medically necessary, authorized by Prominence Preferred and in accordance with Medicare DME guidelines. Limited to one purchase, repair or replacement of a specific item of DME every 3 years from date of service.</p>	<p>CYD/0% coinsurance</p>	<p>CYD/50% coinsurance</p>
<p>Emergency Care – Includes surgeon and physician charges The copay is waived when the member is admitted as an inpatient directly from the emergency room. If you receive services from an out-of-network emergency care provider, you will be responsible for all expenses over and above the usual and customary rate.</p>	<p>CYD/0% coinsurance</p>	

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE PPO IN-NETWORK¹	YOUR OUT-OF-POCKET EXPENSE PPO OUT-OF-NETWORK^{1a}
Urgent Care	CYD/0% coinsurance	CYD/30% coinsurance
Hearing Aids Covered once every 3 years, from date of service.	CYD/0% coinsurance	CYD/30% coinsurance
Home Health Care Limited to 30 visits per calendar year.	CYD/0% coinsurance	CYD/30% coinsurance
Hospice Care	CYD/0% coinsurance	CYD/30% coinsurance
Hospital/Outpatient/Ambulatory Services Ambulatory and day-surgery series performed in a hospital or other facility. <ul style="list-style-type: none"> • Inpatient • Outpatient surgery • Observation – No additional copay if transferred from outpatient surgery • Inpatient skilled nursing – Up to 100 days per calendar year • Acute rehabilitation – Up to 60 visits per condition per member per calendar year 	<p>CYD/0% coinsurance CYD/0% coinsurance CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance CYD/30% coinsurance CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p>
Infusion Therapy <ul style="list-style-type: none"> • Performed and billed by a physician’s office or free-standing facility • Performed and billed by a hospital outpatient facility • In-network Provider-administered specialty infusions 	<p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>Not applicable</p>
Oncology Infusion <ul style="list-style-type: none"> • Performed and billed by a physician’s office or free-standing facility • Performed and billed by a hospital outpatient facility 	<p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p>
Kidney Dialysis Services	CYD/0% coinsurance	CYD/30% coinsurance

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE PPO IN-NETWORK¹	YOUR OUT-OF-POCKET EXPENSE PPO OUT-OF-NETWORK^{1a}
Laboratory	CYD/0% coinsurance	CYD/30% coinsurance
Pathology	CYD/0% coinsurance	CYD/30% coinsurance
Mastectomy Reconstructive Services <ul style="list-style-type: none"> Inpatient surgery Outpatient surgery 	CYD/0% coinsurance CYD/0% coinsurance	CYD/30% coinsurance CYD/30% coinsurance
Maternity <ul style="list-style-type: none"> Physician: Prenatal care and delivery Delivery room and well-baby hospital care Ancillary maternity charges – Including but not limited to fetal non-stress tests and amniocentesis 	CYD/0% coinsurance CYD/0% coinsurance CYD/0% coinsurance	CYD/30% coinsurance CYD/30% coinsurance CYD/30% coinsurance
Medical Nutrition Therapy Counseling Up to 25 visits per calendar year	CYD/0% coinsurance	CYD/30% coinsurance
Mental Health Services – Severe Mental Illness <ul style="list-style-type: none"> Inpatient Day treatment program/Outpatient Outpatient office & telemedicine visit 	CYD/0% coinsurance CYD/0% coinsurance CYD/0% coinsurance	CYD/30% coinsurance CYD/30% coinsurance
Mental Health Services – General Mental Health <ul style="list-style-type: none"> Teladoc mental health services Outpatient office & telemedicine visit 	CYD/0% coinsurance CYD/0% coinsurance	Not applicable CYD/30% coinsurance
Alcohol and Drug Abuse Services <ul style="list-style-type: none"> Inpatient withdrawal/rehabilitation Outpatient rehabilitation/day treatment Outpatient office & telemedicine visit 	CYD/0% coinsurance CYD/0% coinsurance CYD/0% coinsurance	CYD/30% coinsurance CYD/30% coinsurance CYD/30% coinsurance
Bariatric Surgery Includes inpatient or outpatient series. One procedure per lifetime.	CYD/0% coinsurance	CYD/30% coinsurance
Nutritional Supplements Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products.	CYD/0% coinsurance	CYD/30% coinsurance
Organ Transplants	CYD/0% coinsurance	CYD/30% coinsurance
Ostomy Supplies	CYD/0% coinsurance	CYD/30% coinsurance

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE PPO IN-NETWORK ¹	YOUR OUT-OF-POCKET EXPENSE PPO OUT-OF-NETWORK ^{1a}
<p>Preventive Services ² For a complete list of covered services, visit http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/</p> <ul style="list-style-type: none"> • Colorectal cancer screening, colonoscopy, sigmoidoscopy, or fecal occult blood test • Mammograms - baseline and annual (including 3D and breast ultrasound) • Pap and pelvic exams • Periodic health assessments for hearing and vision for ages 19 and under • BRCA genetic counseling and testing services • Prostate screenings • Well baby and child visits, immunizations/ vaccinations for children through age 17 • Preventive sterilization • Preventive services related to infants, children, and adolescents for evidence informed preventive care and screenings 	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p>
<p>Prosthetics and Orthotics</p> <ul style="list-style-type: none"> • Prosthetics and Orthotics – Foot orthotics up to one pair per calendar year • Dental/oral orthotic appliances – TMJ and /or sleep apnea up to one appliance per calendar year 	<p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p>
<p>Radiation Oncology Therapy</p> <ul style="list-style-type: none"> • Specialist office visit • Hospital outpatient therapy facility fee 	<p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p>
<p>Radiology and Diagnostic Services Some invasive diagnostic procedures are treated as outpatient hospital visits</p> <ul style="list-style-type: none"> • Routine X-ray and Routine Diagnostic Tests • CT Scan and MRI • Imaging and Complex Diagnostic Testing 	<p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p> <p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p> <p>CYD/30% coinsurance</p>
<p>Spinal Manipulation Includes all covered services related to the spinal manipulation. Up to 26 visits per year.</p>	<p>CYD/0% coinsurance</p>	<p>CYD/30% coinsurance</p>

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Temporomandibular Joint Dysfunction <ul style="list-style-type: none"> • TMJ surgery – inpatient hospital • TMJ non-surgical outpatient office visit 	CYD/0% coinsurance CYD/0% coinsurance	CYD/30% coinsurance CYD/30% coinsurance
Therapies <ul style="list-style-type: none"> • Physical, occupational and speech – Limited to 120 visits per calendar year for all three therapy types combined. • Autism spectrum disorder – Up to 750 hours per calendar year 	CYD/0% coinsurance CYD/0% coinsurance	CYD/30% coinsurance CYD/30% coinsurance

¹ When travelling or living outside the Prominence UHN service areas, you are eligible to receive medical care by a Cigna PPO Network Provider under your In-Network benefits. To find a Cigna Provider, please visit www.myCigna.com ^{1a} Members who obtain covered benefits from non-plan provider will be responsible for all charges in excess of the Usual and Customary Rate (UCR) charge and you could be responsible for all expenses over and above the UCR. Those charges in excess of the UCR will not be applied to the out-of-pocket maximum. UCR services mean the maximum amount the plan will pay for a covered service.

² Some services listed may be billed as diagnostic procedures, not preventive/screening procedures, which could require a member to pay the share of cost as listed under "Radiology and Diagnostic Services". Diagnostic procedures are usually conducted when a member has already been diagnosed with an illness or disease, or a member is receiving follow-up treatment for an existing medical condition. In addition, a member share of cost might be incurred if additional procedures that are not listed on the "Preventive Services" list are conducted concurrently to the preventive service.

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PRESCRIPTION DRUG COVERAGE**

Visit www.ProminenceHealthPlan.com to obtain updated information regarding the Formulary list, covered and non-covered drugs, and a list of participating pharmacies along with helpful information about generic equivalent drugs.

For more information about your pharmacy benefit, contact Prominence Pharmacy Help Desk at 844-282-5339.

IN-NETWORK PHARMACY	Your Out-of-Pocket Expense RETAIL	Your Out-of-Pocket Expense MAIL ORDER
Tier 0 Essential Health Benefits Includes certain vaccines, contraceptives, smoking cessation medications and more	No Charge	No Charge
Tier 1 Generic	CYD/0% coinsurance	CYD/0% coinsurance
Tier 2 Preferred brand	CYD/0% coinsurance	CYD/0% coinsurance
Tier 3 Non-preferred brand	CYD/0% coinsurance	CYD/0% coinsurance
Tier 4 Specialty drugs	CYD/0% coinsurance	Not available
Diabetic supplies obtainable from a pharmacy (including needles, syringes, test strips, lancets and alcohol swabs available at retail or mail order.		

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Prior authorization

Prior authorization is the standard process of receiving approval for certain procedures and medical services to ensure that the requested medical care is appropriate and necessary. Not all services require a prior authorization from Prominence Health Plan. Your PCP (or specialist) obtains this on your behalf. For a complete list of services that require prior authorization, please visit the member portal on www.ProminenceHealthPlan.com or call 800-863-7515 to confirm if prior authorization has been obtained, if required.

Managing your care with a primary care provider (PCP)

As a Prominence Health Plan PPO member, you can choose from a comprehensive network of providers and services, from primary care providers (PCP), specialists, urgent care clinics, imaging centers, laboratories and more. We encourage you to establish a relationship with your PCP, who can help manage your care and ensure timely receipt of recommended preventive care that may be appropriate. It is always good practice to check with your PCP before seeking care from a specialist. Your PCP can help determine if specialty care (i.e., cardiology, gastroenterology, neurology, etc.) is needed.

Access to pediatricians

For children, you may designate a pediatrician as the primary care provider.

Access to OB/GYN physicians

You do not need prior authorization from Prominence Preferred Health Insurance or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Prominence Health Plan Customer Service.

Rescissions

Prominence Preferred Health Insurance will not rescind coverage once a member is enrolled unless the individual (or a person seeking coverage on behalf of the individual) performs an intentional act, practice or omission that constitutes fraud, or unless the individual makes an intentional material misrepresentation of fact, as prohibited by the terms of the Certificate of Coverage. Prominence Preferred Health Insurance will provide at least 60 days advance written notice to each participant who would be affected before coverage will be rescinded.

Emergency Services are provided as follows:

- a. Without prior authorization requirement, even for out-of-network services;
- b. Without regard to whether the provider of the services is in-network;
- c. If the services are out-of-network, without any administrative requirements or coverage limitations that are more restrictive than those imposed on in-network services; and
- d. Without regard to any other term or condition of the coverage other than: (1) the exclusion of or coordination of benefits; (2) an affiliation or waiting period permitted under ERISA, the PHSA, or the Internal Revenue Code; or (3) applicable cost sharing.
- e. Emergency care services performed by non-network physicians or providers will be reimbursed at the Usual and Customary Rate or at an agreed upon rate.

Language Translation Services

This information is available for free in other languages. Please call Customer Service at 800-863-7515 (TTY: 711) for more information.

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Servicios de traducción de idiomas

Esta información está disponible gratuitamente en otros idiomas. Por favor llame al departamento de servicio de miembros al 800-863-7515 (TTY: 711) para más información.

Notice of Privacy Practices

Member privacy and security are important to Prominence Health Plan. For comprehensive information about how we protect our personal health information (PHI) and how it may be disclosed, refer to the Certificate of Coverage (COC). Once a registered user, you can access the COC within the secure member portal at www.ProminenceMember.com or you can call Customer Service and a copy can be mailed to you.



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, call Customer Service at 800-863-7515 or visit <http://prominencehealthplan.com/>. 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 1-800-433-3077 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$3,400 Individual / \$6,800 Family Out-of-Network: \$6,800 Individual / \$13,600 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. An embedded deductible combines individual and family deductibles in a family health insurance policy. The plan will begin to pay benefits as soon as one member of the family reaches the individual deductible limit.
Are there services covered before you meet your deductible?	Yes. <u>Preventive</u> care and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet the <u>deductible</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$3,400 Individual / \$6,800 Family Out-of-network: \$6,800 Individual / \$13,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. With respect to family plans, an individual is only subject to the individual out-of-pocket maximum amount. When two family members have each satisfied their individual out-of-pocket maximum amount, then the family out-of-pocket amount is met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.prominencehealthplan.com or call 1-800-433-3077 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	CYD/0% coinsurance 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. 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 for.
	Specialist visit	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	
	Preventive care/ screening/immunization	No charge	CYD/30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	CYD/0% coinsurance per test.	CYD/30% coinsurance per test	Some invasive diagnostic procedures are treated as outpatient hospital visits.
		Blood work (Laboratory) - CYD/0% coinsurance	Blood work (Laboratory) - CYD/30% coinsurance	
	Imaging (CT scans, MRIs)	CYD/0% coinsurance per test	CYD/30% coinsurance per test	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com . If PA is not obtained; <u>claims</u> subject to denial.
Complex Diagnostic	CYD/0% coinsurance per test	CYD/30% coinsurance per test	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com . 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition.</p> <p>More information about <u>prescription drug coverage</u> is available at http://www.prominencehealthplan.com/</p>	Generic Drugs	CYD/0% coinsurance	NA	<p><u>Copay</u> applies to 30 day fills for preferred generic and preferred brand drugs. 90 day fills of preferred generic or preferred name brand maintenance medications at retail or mail order are paid at 2 <u>copays</u>. 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 <u>copay</u> will not apply.</p>
	Preferred Brand Drugs	CYD/0% coinsurance	NA	
	Non-Preferred Brand Drugs	CYD/0% coinsurance	NA	
	<u>Specialty Drugs</u>	CYD/0% coinsurance	NA	<p>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 <u>copay</u> will not apply.</p>

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	CYD/0% coinsurance	CYD/30% coinsurance	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com . If PA is not obtained; <u>claims</u> subject to denial.
	Physician/surgeon fees	Included in above	CYD/30% coinsurance	
If you need immediate medical attention	<u>Emergency room care</u>	CYD/0% coinsurance	CYD/0% coinsurance	The <u>copay</u> is waived when the member is admitted as an inpatient directly from the emergency room.
	<u>Emergency medical transportation</u>	Ground - CYD/0% coinsurance Air - CYD/0% coinsurance	Ground -CYD/0% coinsurance Air - CYD/0% coinsurance	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.
	<u>Urgent care</u>	CYD/0% coinsurance	CYD/30% coinsurance	In and Out-of-Area <u>Urgent Care Services</u> are covered for <u>Medically Necessary Covered Services</u> . Members should call 1-800-433-3077 for assistance prior to obtaining Out-of-Area <u>Urgent Care Services</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	CYD/0% coinsurance	CYD/30% coinsurance	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com . If PA is not obtained; <u>claims</u> subject to denial.
	Physician/surgeon fees	Included in above	CYD/30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Office Visit - CYD/0% coinsurance Outpatient Program - CYD/0% coinsurance	Outpatient Office Visit - CYD/30% coinsurance Outpatient Program - CYD/30% coinsuranceper visit	None
	Inpatient services	CYD/0% coinsurance	CYD/30% coinsurance	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com . If PA is not obtained; <u>claims</u> subject to denial.