Prominence Health Plan

SUMMARY OF BENEFITS
PROMINENCE HEALTHFIRST
LARGE GROUP EMPLOYER PLAN

CARSON CITY SCHOOL DISTRICT HMO 2

This disclosure statement provides only a brief description of some important features and limitations of your policy. The Evidence of Coverage (EOC) sets forth in detail the rights and obligations of both you and the insurance company. It is important you review the EOC 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	**Member pays $0 single; $0 family**
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. 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.	
ANNUAL OUT-OF-POCKET MAXIMUM	**Member pays $5,000 single; $10,000 family**
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. NOTE: The out-of-pocket maximums do not apply to or include: • 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	**20% coinsurance**

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SUMMARY OF BENEFITS - COPAYS

TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Provider Office Visits • Priority Care visit • Primary care provider (PCP) office & telemedicine visit • Specialist office & telemedicine visit *Charges in addition to the office visit copay may include* • In-office surgical procedure • In-office injectable (excluding specialty drugs) *There may be additional changes for other services in the provider's office. See this summary of benefits for details.*	 **$0 copay** **$25 copay** **$50 copay** **$250 copay** **20% coinsurance**
Teladoc Telemedicine • Primary Care • Mental Health	 **$0 copay** **$0 copay**
Alternative Medicine Homeopathy, acupuncture and integrated medicine. $1,500 maximum per calendar year.	**$25 copay**
Ambulance Services – Medically necessary only • Air Ambulance • Ground Ambulance	 **$250 copay** **$250 copay**
Durable Medical Equipment Covered when medically necessary, authorized by Prominence HealthFirst 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.	**$25 copay**
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.	**$500 copay**
Urgent Care	**$50 copay**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Hearing Aids Limit one every three years, from date of service	**20% coinsurance**
Home Health Care Limited to 30 visits per calendar year.	**$25 copay**
Hospice Care	**$0 copay**
Hospital/Outpatient/Ambulatory Services Ambulatory and day-surgery series performed in a hospital or other facility. • 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	 **$1,500 copay** **$250 copay** **$1,500 copay** **$1,500 copay** **$1,500 copay**
Infusion Therapy • 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 incur	 **$25 copay** **$250 copay** **20% coinsurance**
Oncology Infusion • Performed and billed by a physician's office or free-standing facility • Performed and billed by a hospital outpatient facility	 **$0 copay** **CYD/20% coinsurance**
Kidney Dialysis Services	**$50 copay**
Laboratory	**$0 copay**
Pathology	**$0 copay**
Mastectomy Reconstructive Services • Inpatient surgery • Outpatient surgery	 **$1,500 copay** **$250 copay**
Maternity • 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	 **$200 copay** **$1,500 copay** **$25 copay**
Medical Nutrition Therapy Counseling Up to 25 visits per calendar year	**$25 copay**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Mental Health Services – Severe Mental Illness	
• Inpatient	**$1,500 copay**
• Day treatment program/Outpatient	**$250 copay**
• Outpatient office & telemedicine visit	**$25 copay**
Mental Health Services – General Mental Health	
• Teladoc mental health services	**$0 copay**
• Outpatient office & telemedicine visit	**$25 copay**
Alcohol and Drug Abuse Services	
• Inpatient withdrawal/rehabilitation	**$1,500 copay**
• Outpatient rehabilitation/day treatment	**$250 copay**
• Outpatient office & telemedicine visit	**$25 copay**
Bariatric Surgery Includes inpatient or outpatient series. One procedure per lifetime.	**$1,5000 copay**
Nutritional Supplements Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products.	**$25 copay**
Organ Transplants	**$1,500 copay**
Ostomy Supplies	**$25 copay**
Preventive Services [1] For a complete list of covered services, visit http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/	
• Colorectal cancer screening, colonoscopy, sigmoidoscopy, or fecal occult blood test	**No Charge**
• Mammograms - baseline and annual (including 3D and breast ultrasound)	**No Charge**
• Pap and pelvic exams	**No Charge**
• Periodic health assessments for hearing and vision for ages 19 and under	**No Charge**
• BRCA genetic counseling and testing services	**No Charge**
• Prostate screenings	**No Charge**
• Well baby and child visits, immunizations/vaccinations for children through age 17	**No Charge**
• Preventive sterilization	**No Charge**
• Preventive services related to infants, children, and adolescents for evidence informed preventive care and screenings	**No Charge**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Prosthetics and Orthotics • 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	**20% coinsurance** **20% coinsurance**
Radiation Oncology Therapy • Specialist office visit • Hospital outpatient therapy facility fee	**$50 copay** **$250 copay**
Radiology and Diagnostic Services Some invasive diagnostic procedures are treated as outpatient hospital visits • Routine X-ray and Routine Diagnostic Tests • CT Scan and MRI • Imaging and Complex Diagnostic Testing	 **$25 copay** **$250 copay** **$250 copay**
Spinal Manipulation Includes all covered services related to the spinal manipulation. Up to 26 visits per year.	**$50 copay**
Temporomandibular Joint Dysfunction • TMJ surgery – inpatient hospital • TMJ non-surgical outpatient office visit	**$1,500 copay** **$50 copay**
Therapies • Physical, occupational and speech – Up to 120 visits per calendar year for all three therapy types combined. • Autism spectrum disorder – Up to 750 hours per calendar year	**$50 copay** **$25 copay**

[1] 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 2 Generic	**$10 copay**	**$20 copay**
Tier 2 Preferred brand	**$30 copay**	**$60 copay**
Tier 3 Non-preferred brand	**$50 copay**	**$150 copay**
Tier 4 Specialty drugs	**20% 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 HealthFirst HMO member, you are encouraged to select a primary care provider (PCP) to help manage all of your medical care. To select or change your PCP, call customer service at 800-863-7515. Please be prepared to indicate your PCP selection. Additionally, 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 HealthFirst 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 HealthFirst 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 Evidence of Coverage. Prominence HealthFirst 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.

Servicios de traducción de idiomas

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Esta infomación está disponible gratuitamente en otros idiomas. Por favor llame al departamento de servicio de miembros al 800-863-7515 (TTY: 711) para mas 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 Evidence of Coverage (EOC). Once a registered user, you can access the EOC 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 1-800-863-7515 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Single / $0 Single	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 don't have to meet the deductible for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,000 Single / $10,000 Family	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.

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	$25 copay per visit	Not Covered	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	$50 copay per visit	Not Covered	
	Preventive care/ screening/immunization	No charge	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay per test. Blood work (Laboratory) - No charge.	Not Covered Not Covered	Some invasive diagnostic procedures are treated as outpatient hospital visits.
	Imaging (CT scans, MRIs)	$250 copay per test	Not Covered	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Complex Diagnostic	$250 copay per test	Not Covered	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
		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** http://www.prominencehealthplan. com/	Generic Drugs	$10 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. 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 or mail order).	Not Covered	
	Non-Preferred Brand Drugs	$50 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. 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	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
		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)	$250 copay	Not Covered	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Physician/surgeon fees	Included in above	Not Covered	
If you need immediate medical attention	Emergency room care	$500 copay per visit	$500 copay per visit	The copay is waived when the member is admitted as an inpatient directly from the emergency room.
	Emergency medical transportation	Ground - $250 copay per trip Air - $250 copay per trip	Ground - $250 copay per trip Air - $250 copay per trip	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	$50 copay per visit	Not Covered	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)	$1,500 copay per admit	Not Covered	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Physician/surgeon fees	Included in above	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Office Visit - $25 copay per visit Outpatient Program - $250 copay per visit	Not Covered	None
	Inpatient services	$1,500 copay per admit	Not Covered	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copay per visit	Not Covered	Copay applies to all Obstetrician services associated with the birth. Well Woman prenatal visits are covered without share of cost. 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	$200 copay per delivery	Not Covered	
	Childbirth/delivery facility services	$1,500 copay per admit	Not Covered	
If you need help recovering or have other special health needs	Home health care	$25 copay per visit	Not Covered	Maximum 30 visits per calendar year. Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Rehabilitation services	$50 copay per visit	Not Covered	Limited to 60 visits per condition per member per calendar year (combined with Acute Rehabilitation visits). Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Habilitation services	$50 copay per visit	Not Covered	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Skilled nursing care	$1,500 copay per admit	Not Covered	Limited to 100 days per calendar year. Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Durable medical equipment	Rental - $25 copay per item Purchase - $25 copay per item	Not Covered	Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial.
	Hospice service	No charge	Not Covered	None

. or more information about limitations and exceptions, see the plan or policy document at http://prominencehealthplan.com/

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 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: http://prominencehealthplan.com. You may also contact your state insurance department at 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. 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.

. or more information about limitations and exceptions, see the plan or policy document at http://prominencehealthplan.com/

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 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*----------

. or more information about limitations and exceptions, see the plan or policy document at http://prominencehealthplan.com/

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: $0**
- **Specialist copayment: $50 copay per visit**
- **Hospital (facility) copayment: $1,500 copay per admit**
- **Other coinsurance: N/A**

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	

In this example, Peg would pay:

Cost Sharing	
Deductibles	
Copays	
Coinsurance	
What isn't covered	
Limits or exclusions	
The total Peg would pay is	

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

- **The plan's overall deductible: $0**
- **Specialist copayment: $50 copay per visit**
- **Hospital (facility) copayment: $1,500 copay per admit**
- **Other coinsurance: N/A**

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	

In this example, Joe would pay:

Cost Sharing	
Deductibles	
Copays	
Coinsurance	
What isn't covered	
Limits or exclusions	
The total Joe would pay is	

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

- **The plan's overall deductible: $0**
- **Specialist copayment: $50 copay per visit**
- **Hospital (facility) copayment: $1,500 copay per admit**
- **Other coinsurance: N/A**

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	

In this example, Mia would pay:

Cost Sharing	
Deductibles	
Copays	
Coinsurance	
What isn't covered	
Limits or exclusions	
The total Mia would pay is	

The **plan** would be responsible for the other costs of these EXAMPLE covered services.