**SUMMARY OF BENEFITS**
**PROMINENCE HEALTHFIRST**
**LARGE GROUP EMPLOYER PLAN**

# WASHOE COUNTY HMO

**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. | |
| **ANNUAL OUT-OF-POCKET MAXIMUM** | **Member pays $3,500 single; $7,000 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.**<br>NOTE: The out-of-pocket maximums do not apply to or include:<br>• expenses which are not covered by the Plan, for any reason;<br>• expenses in excess of Usual and Customary; and<br>• expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program. | |
| **COINSURANCE** | **0%** |

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### SUMMARY OF BENEFITS

| TYPE OF SERVICE | YOUR OUT-OF-POCKET EXPENSE |
|---|---|
| **Provider Office Visits**<br>• Telemedicine services<br>• Primary care provider (PCP)<br>• Specialist office visit<br>*Charges in addition to the office visit copay may include*<br>• In-office surgical procedure – primary care office<br>• In-office surgical procedure – specialist office<br>• In-office injectable (excluding specialty drugs)<br>*There may be additional changes for other services in the provider's office. See this summary of benefits for details.* | <br>**$0 copay**<br>**$30 copay**<br>**$50 copay**<br><br>**$30 copay per procedure**<br>**$50 copay per procedure**<br>**$50 copay per procedure** |
| **Prominence Care Centers**<br>• Office Visit<br>• Lab<br>• Pharmacy | <br>**$0 copay**<br>**$0 copay**<br>**$0 copay** |
| **Emergency Care – Includes surgeon and physician charges**<br>The copay is waived when the member is admitted as an inpatient or for observation 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. | **$250 copay** |
| **Ambulance Services – Medically necessary only**<br>• Air Ambulance<br>• Ground Ambulance | <br>**$200 copay**<br>**$100 copay** |
| **Urgent Care** | **$40 copay** |
| **Hospital/Outpatient/Ambulatory Services**<br>Ambulatory and day-surgery series performed in a hospital or other facility.<br>• Inpatient admission/stay<br>• Outpatient surgery<br>• Observation – No additional copay if transferred from outpatient surgery<br>• Acute rehabilitation – Up to 60 visits per condition per member per calendar year | <br><br><br>**$1,000 copay per admit**<br>**$500 copay per procedure**<br>**$500 copay per admit**<br><br>**$1,000 copay per admit** |

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|---|---|
| **Maternity** | |
| • Physician: Prenatal care and delivery | **$0 copay per delivery** |
| • Delivery room and well-baby hospital care | **$1,000 copay** |
| • Ancillary maternity charges – Including but not limited to fetal non-stress tests and amniocentesis | **$30 copay** |
| **Laboratory** | **$0 copay** |
| **Pathology** | **$0 copay** |
| **General Mental Health Services** | |
| • Telemedicine services | **$0 copay** |
| • Outpatient office visit | **$30 copay** |
| **Severe Mental Health/Illness Services** | |
| • Inpatient | **$1,000 copay** |
| • Day treatment program/Outpatient | **$30 copay per visit** |
| • Outpatient office visit | **$30 copay** |
| **Alcohol and Drug Abuse Services** | |
| • Inpatient withdrawal/rehabilitation | **$1,000 copay** |
| • Outpatient rehabilitation/day treatment | **$30 copay per visit** |
| • Outpatient office visit | **$30 copay** |
| **Preventive Services** [1]<br>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, annual and 3D | **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** |
| • Prenatal well visits | **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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|---|---|
| **Radiology and Diagnostic Services**<br>Some invasive diagnostic procedures are treated as outpatient hospital visits.<br>• Routine X-ray and Routine Diagnostic Tests<br>• CT Scan and MRI<br>• Complex Diagnostic Testing | <br><br><br>**$30 copay**<br>**$225 copay**<br>**$225 copay** |
| **Alternative Medicine**<br>Homeopathy, acupuncture and integrated medicine. Limited to 20 visits per calendar year. | **$50 copay** |
| **Durable Medical Equipment**<br>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.<br>• Rental<br>• Items approved for purchase | <br><br><br><br>**$0 copay**<br>**$0 copay** |
| **Home Health Care**<br>Limited to 30 visits per plan year. | **$30 copay per visit** |
| **Hospice Care** | **$0 copay** |
| **Infusion Therapy**<br>• Performed and billed by a physician's office, free-standing facility or the covered person's home<br>• Performed and billed by a hospital outpatient facility<br>• Provider-administered specialty infusions | <br>**$50 copay**<br><br>**$50 copay**<br>**$50 copay** |
| **Inpatient skilled nursing**<br>Up to 100 days per calendar year. | **$1,000 copay per admit** |
| **Kidney Dialysis Services**<br>Covered to the extent not covered by Medicare. | **$50 copay per visit** |
| **Mastectomy Reconstructive Services**<br>• Inpatient surgery<br>• Outpatient surgery | <br>**$1,000 copay per admit**<br>**$500 copay per procedure** |
| **Medical Nutrition Therapy Counseling**<br>Up to 25 visits per calendar year | **$30 copay** |
| **Morbid Obesity**<br>Includes inpatient or outpatient series. One procedure per lifetime. | **$500 copay** |
| **Nutritional Supplements**<br>Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products. | **$30 copay per 30-day supply** |
| **Organ Transplants** | **$1,000 copay** |

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|---|---|
| **Ostomy Supplies** | **$30 copay per 30-day supply** |
| **Prosthetics and Orthotics**<br>• Prosthetics and Orthotics – Foot orthotics up to one pair per member per calendar year<br>• Dental/oral orthotic appliances – TMJ and /or sleep apnea up to one appliance per member per calendar year | <br>**$30 copay per item**<br>**$30 copay per item** |
| **Radiation Oncology Therapy**<br>• Specialist office visit<br>• Hospital outpatient therapy facility fee | <br>**$50 copay**<br>**$50 copay** |
| **Spinal Manipulation**<br>Includes all covered services related to the spinal manipulation. Up to 26 visits per plan year. | **$50 copay** |
| **Temporomandibular Joint Dysfunction**<br>• TMJ surgery – inpatient hospital<br>• TMJ non-surgical outpatient office visit | <br>**$1,000 copay**<br>**$50 copay** |
| **Therapies**<br>• Physical, occupational and speech – Up to 90 visits per condition per member per calendar year<br>• Autism spectrum disorder – Up to 750 hours per member per calendar year<br>• Wound Therapy – Outpatient hospital or facility (Wound therapy in an office-based setting, see the Provider Office Visit section of this Summary of Benefits.) | <br>**$30 copay per visit**<br>**$30 copay per visit**<br>**$30 copay per visit** |

[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

The Prescription Drug Program is administered and provided through MedImpact, a Pharmacy Benefit Manager (PBM). 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 MedImpact Pharmacy Help Desk at 844-282-5339.

| **MEDICAL PHARMACY and IMMUNIZATIONS**<br>Received in a provider's office, facility, or at the covered member's home | | **Your Out-of-Pocket Expense** |
|---|---|---|
| **Special pharmaceuticals** | | **$75 copay** |
| **Covered immunizations** | | **$0 copay** |
| **All other medical pharmacy** | | **$40 copay** |
| **IN-NETWORK PHARMACY** | **Your Out-of-Pocket Expense RETAIL** | **Your Out-of-Pocket Expense MAIL ORDER (90-day supply)** |
| **Tier 1 Essential Health Benefits**<br>Includes certain vaccines, contraceptives, smoking cessation medications and more | **No Charge** | **$0 copay** |
| **Tier 2 Generic** | **$7 copay** | **$14 copay** |
| **Tier 3 Preferred brand**<br>• Preferred Brand without a Formulary Generic alternative<br>• Preferred Brand drugs with a Formulary Generic alternative | **$30 copay**<br><br>**$30 copay/script plus the Ancillary Charge** | **$60 copay** |
| **Tier 4 Non-preferred brand**<br>• Non-preferred brand without a Formulary Generic alternative<br>• Non-preferred brand drugs with a Formulary Generic alternative | **$50 copay**<br><br>**$50 copay/script plus the Ancillary Charge** | **$100 copay** |
| **Tier 5 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.<br>• Orally administered chemotherapy cost sharing will not exceed $100 per 30-day supply except for Members who select a Non-Formulary drug with a Formulary alternative. | | |

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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**

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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**
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.