Prominence Health Plan

Summary of Benefits

Prominence HealthFirst
Small Group Health Plan

Triple Choice Silver

Type of Service	Your Out-of-Pocket Expense HMO In-Network[1]	Your Out-of-Pocket Expense PPO In-Network[2]	Your Out-of-Pocket Expense PPO Out-of-Network[3,4]
Calendar Year Deductible (CYD)	$3,000 Single / $9,000 Family	$7,000 Single / $14,000 Family	$21,000 Single / $42,000 Family
Coinsurance	40% coinsurance	50% coinsurance	50% coinsurance
Out-of-Pocket Maximum[5] - Deductibles, coinsurance and copays accrue toward the out-of-pocket maximum.	$7,350 Single / $14,700 Family	$7,350 Single / $14,700 Family	$22,050 Single / $44,100 Family
Physician Office Visits			
• Telemedicine services	$50 copay	$100 copay	CYD/Coinsurance
• Primary care practitioner (PCP)	$50 copay	$100 copay	CYD/Coinsurance
• Specialist office visit[6]	$80 copay	$150 copay	CYD/Coinsurance
Charges in addition to the office visit copay may include			
• In-office surgical procedure	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• In-office injectable (excluding specialty drugs)	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
There may be additional charges for other services in the provider's office. See this summary of benefits for details.			
Alternative Medicine - Homeopathy, acupuncture and integrated medicine. $1,500 maximum per calendar year; in-network and out-of-network combined. Initial self referral HMO only.	$80 copay	$150 copay	CYD/Coinsurance
Ambulance Services - Medically necessary only.			
• Air ambulance	CYD/40% Coinsurance	CYD/40% Coinsurance	CYD/40% Coinsurance
• Ground ambulance	CYD/40% Coinsurance	CYD/40% Coinsurance	CYD/40% Coinsurance
Durable Medical Equipment[7]			
• Rental or purchase	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Emergency Care - Includes surgeon and physician costs.			
• Emergency room - 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 provider, you may be responsible for paying the difference between the billed charges and the plan's allowable amount. The plan's allowable amount is the amount the plan would have paid to an in-network provider.	CYD/40% Coinsurance	CYD/40% Coinsurance	CYD/40% Coinsurance
• Urgent care	$100 copay	$150 copay	CYD/Coinsurance
Health and Wellness Services			
• Online Wellness Assessment - OWA Link: prominencehealthplan.com	No charge	No charge	Not Covered
Hearing Aids - Up to one every three years.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance

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Home Health Care - Includes private-duty nursing.	$50 copay	$100 copay	CYD/Coinsurance
Hospice Care			
• Hospice care	$80 copay	$150 copay	CYD/Coinsurance
• Respite inpatient - Up to 10 days per 6 months.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Respite outpatient - Up to 10 visits per year.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Bereavement services - Up to 5 visits per year.	$80 copay	$150 copay	CYD/Coinsurance
Hospital/Outpatient/Ambulatory Services[8]			
• Inpatient	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Outpatient surgery	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Observation	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Inpatient skilled nursing - Up to 100 days per calendar year in-network and out-of-network combined.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Acute rehabilitation - Up to 60 days per calendar year in-network and out-of-network combined.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Infertility Treatment Services			
• Office visit evaluation - Please refer to the applicable surgical procedure copay and/or coinsurance amount for any surgical infertility procedures performed.	$80 copay	$150 copay	CYD/Coinsurance
Infusion Therapy			
• Performed and billed by a physician's office or free-standing outpatient facility	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Performed and billed by a hospital outpatient facility	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• In-network Specialty drugs incur	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Kidney Dialysis Services - Covered to the extent not covered by Medicare.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Laboratory and Pathology Services			
• Laboratory	No charge	CYD/Coinsurance	CYD/Coinsurance
• Pathology	No charge	CYD/Coinsurance	CYD/Coinsurance
Mastectomy Reconstructive Services			
• Inpatient surgery	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Outpatient surgery	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance

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Maternity			
• Physician: prenatal care and delivery	$200 copay per delivery	CYD/Coinsurance	CYD/Coinsurance
• Delivery room and well-baby hospital care	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Ancillary maternity charges - including but not limited to fetal non-stress tests and amniocentesis	$50 copay	$100 copay	CYD/Coinsurance
Medical Nutrition Therapy Counseling - Up to 25 visits per calendar year; in-network and out-of-network combined.	$80 copay	$150 copay	CYD/Coinsurance
Mental Health Services			
Severe Mental Illness			
•Inpatient	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
•Day treatment program	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
•Outpatient	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
•Outpatient office visit	$50 copay	$100 copay	CYD/Coinsurance
General Mental Health			
•Outpatient office visit	$50 copay	$100 copay	CYD/Coinsurance
Alcohol and Drug Abuse Services			
•Inpatient withdrawal	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
•Inpatient rehabilitation	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
•Outpatient rehabilitation/day treatment	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
•Outpatient office visit	$50 copay	$100 copay	CYD/Coinsurance
Morbid Obesity - Bariatric Gastric Restrictive surgery. One procedure per lifetime.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Nutritional Supplements - Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Organ Transplants	CYD/Coinsurance	Covered under HMO only	Covered under HMO only
Ostomy Supplies - Per 30 day supply	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Pediatric Dental - Pediatric Dental Coverage up to Age 19			
• Diagnostic and Preventive Services - Not subject to the deductible	N/A	No charge	30% Coinsurance
• Basic Restorative Procedures - Subject to the deductible	N/A	20% Coinsurance	50% Coinsurance
• Major Restorative Procedures - Subject to the deductible	N/A	50% Coinsurance	80% Coinsurance
• Orthodontia - Subject to the deductible	N/A	50% Coinsurance	80% Coinsurance

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Preventive Services[9] - 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	No charge	Not Covered
• Mammograms - baseline and annual	No charge	No charge	Not Covered
• Pap and pelvic exams	No charge	No charge	Not Covered
• Periodic health assessments for hearing and vision for ages 19 and under	No charge	No charge	Not Covered
• BRCA genetic counseling and testing services	No charge	No charge	Not Covered
• Prenatal well visits	No charge	No charge	Not Covered
• Prostate screenings			
• Well baby and child visits, immunizations/vaccinations for children through age 17	No charge	No charge	Not Covered
• Preventive sterilization	No charge	No charge	Not Covered
Prosthetics and Orthotics			
• Prosthetics and orthotics - Foot orthotics limited to one pair per member per calendar year; in-network and out-of-network combined.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Dental/Oral Orthotic Appliances, TMJ and/or Sleep Apnea Limited to one appliance per member per calendar year.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Radiation Oncology Therapy			
• Specialist office visit	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• Hospital outpatient therapy – facility fee	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Radiology and Diagnostic Services[10]			
Routine X-ray and Routine Diagnostic Tests			
• Performed and billed by a physician's office or free-standing outpatient facility	$90 copay	$150 copay	CYD/Coinsurance
• Performed in and billed by a hospital outpatient facility	$180 copay	$300 copay	CYD/Coinsurance
Imaging and Complex Diagnostic Tests			
• Performed and billed by a physician's office or free-standing outpatient facility	CYD/$225 copay	CYD/Coinsurance	CYD/Coinsurance
• Performed and billed by a hospital outpatient facility	CYD/$500 copay	CYD/Coinsurance	CYD/Coinsurance

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Spinal Manipulation - Includes all covered services related to the spinal manipulation. Up to 26 Visits per year.	$80 copay	$150 copay	CYD/Coinsurance
Temporomandibular Joint Dysfunction			
• TMJ surgery - inpatient hospital	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
• TMJ non-surgical outpatient office visit	$80 copay	$150 copay	CYD/Coinsurance
Therapies			
• Physical, occupational and speech - Up to 60 visits per condition per member per calendar year.	$80 copay	$150 copay	CYD/Coinsurance
• Habilitative - Up to 60 visits per condition per member per calendar year.	$80 copay	$150 copay	CYD/Coinsurance
• Rehabilitative - Up to 60 visits per condition per member per calendar year.	$80 copay	$150 copay	CYD/Coinsurance
• Autism spectrum disorders - Up to 750 hours per member per calendar year.	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
Vision - Pediatric - Coverage up to age 19			
• Eye exam - Up to one routine eye exam per child per year.	No charge	CYD/50% coinsurance	CYD/50% coinsurance
• Low-vision exam - Up to one routine eye exam per child per year.	No charge	CYD/50% coinsurance	CYD/50% coinsurance
• Glasses - Up to one pair of basic frames and lenses.	No charge	CYD/50% coinsurance	CYD/50% coinsurance
• Post-cataract services - Up to one pair of basic frames and lenses.	$100 copay	CYD/50% coinsurance	CYD/50% coinsurance

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Prescription Coverage	Your Out-of-Pocket Expense HMO In-Network[3]	Your Out-of-Pocket Expense PPO In-Network[2]	Your Out-of-Pocket Expense PPO Out-of-Network[1,2]
In-network Pharmacy			
• FDA-approved formulary preventive medications, including female oral contraceptives	$0 copay	$0 copay	Not Covered
• Generic	$30 copay	$30 copay	CYD/Coinsurance
• Preferred brand	$60 copay	$60 copay	CYD/Coinsurance
• Non-preferred brand	$90 copay	$90 copay	CYD/Coinsurance
• Specialty drugs	CYD/Coinsurance	CYD/Coinsurance	CYD/Coinsurance
PharmacyPlus			
• PharmacyPlus generic	$25 copay	$25 copay	Not applicable
• PharmacyPlus brand	$55 copay	$55 copay	Not applicable

Members have the option to fill certain available prescriptions at PharmacyPlus locations for a discounted copay amount. For a complete list of PharmacyPlus locations, please refer to the provider directory.

Provider directories can be found online at www.prominencehealthplan.com.

Diabetic supplies obtainable from a pharmacy (including: needles, syringes, test strips, lancets and alcohol swabs) available at retail or mail order.

(EOC) sets forth in detail the rights and obligation of both you and the insurance company. It is important you review the EOC once you are enrolled.

For HMO benefits, except for an emergency, all healthcare services must be coordinated by a plan practitioner/provider and prior authorized by Prominence HealthFirst.

Prior authorization means the process by which a plan practitioner/provider must justify the need for delivering a covered service or medication to a Plan Member and obtain approval from the plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment; payment is dependent upon eligibility at the time covered services are received.

All PPO In-Network and Non PPO Out-of-Network Maximums are combined.

1. The Out-of-Pocket Maximum for the HMO (Tier 1) is the combined total expense paid by a Member as deductible, coinsurance and copayments for all covered services in a Calendar Year. It does not include: a) any expenditures for reduction in benefits resulting from a Member's failure to comply with the Utilization Management Program; b) any expenses for covered services in excess of Eligible Medical Expense Charges; c) expenses for which no benefits are payable by the Plan; or d) expenses a Member must pay because benefits paid by the Plan have reached the Calendar Year maximum benefit set forth by the Plan.
2. The Out-of-Pocket Maximum for PPO In-Network (Tier 2) is the combined total expense paid by a Member as deductible and coinsurance, and copayments for all covered services in a Calendar Year. It does not include: a) any expenditures for reductions in benefits resulting from a Member's failure to comply with the Utilization

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Management Program; b) any expenses for covered services in excess of Eligible Medical Expense Charges; c) expenses for which no benefits are payable by the Plan; or d) expenses a Member must pay because benefits paid by the Plan have reached the Calendar Year maximum benefit set forth by the Plan.

3. The Out-of-Pocket Maximum for PPO Out-of-Network (Tier 3) is the combined total expense paid by a Member as deductible and coinsurance, and copayments for all covered services in a Calendar Year. It does not include: a) any expenditures for reductions in benefits resulting from a Member's failure to comply with the Utilization Management Program; b) any expenses for covered services in excess of Eligible Medical Expense Charges; c) expenses for which no benefits are payable by the Plan; or d) expenses a Member must pay because benefits paid by the Plan have reached the Calendar Year maximum benefit set forth by the Plan.
4. PPO Out-of-Network - Members who obtain Covered Benefits from an Out-of-Network Provider will be responsible for all charges in excess of the Eligible Medical Expense charges. Those charges in excess of the Eligible Medical Expense will not be applied to the annual Out-of-Pocket Maximum. Eligible Medical Expense Services means the maximum amount the Plan will pay for a Covered Service.
5. Your Out-of-Pocket expenses for HMO (Tier 1) accumulate toward both your HMO (Tier 1) and PPO In-Network (Tier 2) out-of-pocket maximums. Your out-of-pocket expenses for PPO In-Network (Tier 2) accumulate toward your PPO In-Network (Tier 2) and HMO (Tier 1) calendar year out-of-pocket maximums. In no event will your out-of-pocket expenses for HMO (Tier 1) and PPO In-Network (Tier 2) exceed your PPO In-Network (Tier 2) Out-of-Pocket Maximum.
6. Members may be required to obtain a primary care practitioner (PCP) referral to see a specialist under the HMO tier.
7. Durable Medical Equipment is covered for inpatient and outpatient, when medically necessary, authorized by Prominence HealthFirst and in accordance with Medicare DME guidelines.
8. Ambulatory and day surgery services performed in a Hospital or other facility.
9. 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.
10. Some invasive diagnostic procedures require an outpatient hospital copayment.

Choosing your Primary Care Provider

Prominence HealthFirst generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. It is always a good idea to check with your PCP before seeking care from a specialist. Your PCP can help you determine if specialty care (i.e., cardiology, gastroenterology, neurology, etc.) is needed.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Prominence Health Plan Customer Service at 775.770.9310 and 800.863.7515.

Access to Pediatricians

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

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Access to OB/GYN Physicians

You do not need prior authorization from Prominence HealthFirst or from any other person (including a primary care provider) 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 or following a pre-approved treatment plan. 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 30 days advance written notice to each participant who would be affected before coverage will be rescinded.

Emergency Services

Emergency Services at Prominence Health Plan are provided as follows:

a. Without prior authorization requirements;
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. Out-of-network emergency services may be subject to additional charges above the allowable amount (what the plan would have paid an in-network provider).

Language Translation Services

This information is available for free in other languages. Please call Customer Service at 800-326-6868 (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 800326-6868 (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 your personal health information (PHI) and how it may be disclosed, refer to the Evidence of Coverage (EOC). You can access the EOC online at www.prominencehealthplan.com or call Customer Service and a copy can be mailed to you.

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