SUMMARY OF BENEFITS
PROMINENCE HEALTHFIRST
LARGE GROUP EMPLOYER PLAN

AHP HMO 1000

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 $1,000 single; $3,000 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 $4,000 single; $8,000 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 • 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.*	 **$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 per trip** **$250 copay per trip**
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. • Rental • Items approved for purchase	 **$25 copay** **$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 Covered once 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	 **CYD/$1,000 copay** **$250 copay** **$1,000 copay** **CYD/$1,000 copay** **CYD/$1,000 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	 **$25 copay** **$250 copay** **20% coinsurance**
Oncology Infusion Select oncology treatments are provided at $0 copay to the member if administered in a physician's office or at a free-standing facility. For a complete list of covered services, visit www.prominencehealthplan.com/selectoncologyinfusion • Performed and billed by a physician's office or free-standing facility • Performed and billed by a hospital outpatient facility	 **$0 copay** **$250 copay**
Kidney Dialysis Services	**$50 copay**
Laboratory	**No Charge**
Pathology	**No Charge**
Mastectomy Reconstructive Services • Inpatient surgery • Outpatient surgery	 **CYD/$1,000 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 per delivery** **CYD/$1,000 copay** **$25 copay**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Medical Nutrition Therapy Counseling Up to 25 visits per calendar year	**$25 copay**
Mental Health Services – Severe Mental Illness • Inpatient • Day treatment program/Outpatient • Outpatient office & telemedicine visit	 **CYD/$1,000 copay** **$250 copay** **$25 copay**
Mental Health Services – General Mental Health • Teladoc mental health services • Outpatient office & telemedicine visit	 **$0 copay** **$25 copay**
Alcohol and Drug Abuse Services • Inpatient withdrawal/rehabilitation • Outpatient rehabilitation/day treatment • Outpatient office & telemedicine visit	 **CYD/$1,000 copay** **$250 copay** **$25 copay**
Bariatric Surgery Includes inpatient or outpatient series. One procedure per lifetime.	**CYD/$1,000 copay**
Nutritional Supplements Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products.	**$25 copay**
Organ Transplants	**CYD/$1,000 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 • 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	 **No Charge** **No Charge** **No Charge** **No Charge** **No Charge** **No Charge** **No Charge** **No Charge** **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 calendar year	**20% coinsurance**
• Dental/oral orthotic appliances – TMJ and /or sleep apnea up to one appliance per calendar year	**20% coinsurance**
Radiation Oncology Therapy	
• Specialist office visit	**$50 copay**
• Hospital outpatient therapy facility fee	**$250 copay**
Radiology and Diagnostic Services Some invasive diagnostic procedures are treated as outpatient hospital visits	
• Routine X-ray and Routine Diagnostic Tests	**$25 copay**
• CT Scan and MRI	**$250 copay**
• Imaging and Complex Diagnostic Testing	**$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	**CYD/$1,000 copay**
• TMJ non-surgical outpatient office visit	**$50 copay**
Therapies	
• Physical, occupational and speech – Up to 120 visits per calendar year for all three therapy types combined.	**$50 copay**
• Autism spectrum disorder – Up to 750 hours per calendar year	**$25 copay**
Pediatric Dental (In-Network) – Coverage up to Age 19	
• Diagnostic and preventive services (not subject to deductible)	**No Charge**
• Basic restorative procedures (subject to the deductible)	**20% coinsurance**
• Major restorative procedures (subject to the deductible)	**50% coinsurance**
• Orthodontia (subject to the deductible)	**50% coinsurance**
Pediatric Vision – Coverage up to Age 19	
• Eye exam – Up to one routine eye exam per child per year	**No Charge**
• Low-vision exam – Up to one routine eye exam per child per year	**No Charge**
• Glasses – Up to one pair of basic frames and lenses	**No Charge**
• Post-cataract services – Up to one pair of basic frames and lenses	**$100 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**	**$0 copay**
Tier 1 Generic	**$25 copay**	**$50 copay**
Tier 2 Preferred brand	**$50 copay**	**$100 copay**
Tier 3 Non-preferred brand	**$75 copay**	**$225 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.

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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.