

**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](http://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)**

<b>CALENDAR YEAR DEDUCTIBLE</b>	<b>Member pays \$0 single; \$0 family</b>
<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>	
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>	<b>Member pays \$5,000 single; \$10,000 family</b>
<p><b>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.</b></p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> <li>• expenses which are not covered by the Plan, for any reason;</li> <li>• expenses in excess of Usual and Customary; and</li> <li>• expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.</li> </ul>	
<b>COINSURANCE</b>	<b>20% coinsurance</b>

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**SUMMARY OF BENEFITS - COPAYS**

TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
<p><b>Provider Office Visits</b></p> <ul style="list-style-type: none"> <li>• Priority Care visit</li> <li>• Primary care provider (PCP) office &amp; telemedicine visit</li> <li>• Specialist office &amp; telemedicine visit</li> </ul> <p><i>Charges in addition to the office visit copay may include</i></p> <ul style="list-style-type: none"> <li>• In-office surgical procedure</li> <li>• In-office injectable (excluding specialty drugs)</li> </ul> <p><i>There may be additional charges for other services in the provider's office. See this summary of benefits for details.</i></p>	<p><b>\$0 copay</b> <b>\$25 copay</b> <b>\$50 copay</b></p> <p><b>\$250 copay</b> <b>20% coinsurance</b></p>
<p><b>Teladoc Telemedicine</b></p> <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Mental Health</li> </ul>	<p><b>\$0 copay</b> <b>\$0 copay</b></p>
<p><b>Alternative Medicine</b> Homeopathy, acupuncture and integrated medicine. \$1,500 maximum per calendar year.</p>	<p><b>\$25 copay</b></p>
<p><b>Ambulance Services – Medically necessary only</b></p> <ul style="list-style-type: none"> <li>• Air Ambulance</li> <li>• Ground Ambulance</li> </ul>	<p><b>\$250 copay</b> <b>\$250 copay</b></p>
<p><b>Durable Medical Equipment</b> 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.</p>	<p><b>\$25 copay</b></p>
<p><b>Emergency Care – Includes surgeon and physician charges</b> 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><b>\$500 copay</b></p>
<p><b>Urgent Care</b></p>	<p><b>\$50 copay</b></p>

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<b>Hearing Aids</b> Limit one every three years, from date of service	20% coinsurance
<b>Home Health Care</b> Limited to 30 visits per calendar year.	\$25 copay
<b>Hospice Care</b>	\$0 copay
<b>Hospital/Outpatient/Ambulatory Services</b> Ambulatory and day-surgery series performed in a hospital or other facility. <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient surgery</li> <li>• Observation – No additional copay if transferred from outpatient surgery</li> <li>• Inpatient skilled nursing – Up to 100 days per calendar year</li> <li>• Acute rehabilitation – Up to 60 visits per condition per member per calendar year</li> </ul>	\$1,500 copay \$250 copay \$1,500 copay \$1,500 copay \$1,500 copay
<b>Infusion Therapy</b> <ul style="list-style-type: none"> <li>• Performed and billed by a physician’s office or free-standing facility</li> <li>• Performed and billed by a hospital outpatient facility</li> <li>• In-network Provider administered specialty infusions incur</li> </ul>	\$25 copay \$250 copay 20% coinsurance
<b>Oncology Infusion</b> <ul style="list-style-type: none"> <li>• Performed and billed by a physician’s office or free-standing facility</li> <li>• Performed and billed by a hospital outpatient facility</li> </ul>	\$0 copay CYD/20% coinsurance
<b>Kidney Dialysis Services</b>	\$50 copay
<b>Laboratory</b>	\$0 copay
<b>Pathology</b>	\$0 copay
<b>Mastectomy Reconstructive Services</b> <ul style="list-style-type: none"> <li>• Inpatient surgery</li> <li>• Outpatient surgery</li> </ul>	\$1,500 copay \$250 copay
<b>Maternity</b> <ul style="list-style-type: none"> <li>• Physician: Prenatal care and delivery</li> <li>• Delivery room and well-baby hospital care</li> <li>• Ancillary maternity charges – Including but not limited to fetal non-stress tests and amniocentesis</li> </ul>	\$200 copay \$1,500 copay \$25 copay
<b>Medical Nutrition Therapy Counseling</b> Up to 25 visits per calendar year	\$25 copay

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
<b>Mental Health Services – Severe Mental Illness</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Day treatment program/Outpatient</li> <li>• Outpatient office &amp; telemedicine visit</li> </ul>	<b>\$1,500 copay</b> <b>\$250 copay</b> <b>\$25 copay</b>
<b>Mental Health Services – General Mental Health</b> <ul style="list-style-type: none"> <li>• Teladoc mental health services</li> <li>• Outpatient office &amp; telemedicine visit</li> </ul>	<b>\$0 copay</b> <b>\$25 copay</b>
<b>Alcohol and Drug Abuse Services</b> <ul style="list-style-type: none"> <li>• Inpatient withdrawal/rehabilitation</li> <li>• Outpatient rehabilitation/day treatment</li> <li>• Outpatient office &amp; telemedicine visit</li> </ul>	<b>\$1,500 copay</b> <b>\$250 copay</b> <b>\$25 copay</b>
<b>Bariatric Surgery</b> Includes inpatient or outpatient series. One procedure per lifetime.	<b>\$1,500 copay</b>
<b>Nutritional Supplements</b> Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products.	<b>\$25 copay</b>
<b>Organ Transplants</b>	<b>\$1,500 copay</b>
<b>Ostomy Supplies</b>	<b>\$25 copay</b>
<b>Preventive Services <sup>1</sup></b> For a complete list of covered services, visit <a href="http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/">http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/</a> <ul style="list-style-type: none"> <li>• Colorectal cancer screening, colonoscopy, sigmoidoscopy, or fecal occult blood test</li> <li>• Mammograms - baseline and annual (including 3D and breast ultrasound)</li> <li>• Pap and pelvic exams</li> <li>• Periodic health assessments for hearing and vision for ages 19 and under</li> <li>• BRCA genetic counseling and testing services</li> <li>• Prostate screenings</li> <li>• Well baby and child visits, immunizations/vaccinations for children through age 17</li> <li>• Preventive sterilization</li> <li>• Preventive services related to infants, children, and adolescents for evidence informed preventive care and screenings</li> </ul>	<b>No Charge</b>  <b>No Charge</b>  <b>No Charge</b> <b>No Charge</b>  <b>No Charge</b> <b>No Charge</b> <b>No Charge</b>  <b>No Charge</b> <b>No Charge</b>

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
<b>Prosthetics and Orthotics</b> <ul style="list-style-type: none"> <li>• Prosthetics and Orthotics – Foot orthotics up to one pair per calendar year</li> <li>• Dental/oral orthotic appliances – TMJ and /or sleep apnea up to one appliance per calendar year</li> </ul>	<b>20% coinsurance</b>  <b>20% coinsurance</b>
<b>Radiation Oncology Therapy</b> <ul style="list-style-type: none"> <li>• Specialist office visit</li> <li>• Hospital outpatient therapy facility fee</li> </ul>	<b>\$50 copay</b> <b>\$250 copay</b>
<b>Radiology and Diagnostic Services</b> Some invasive diagnostic procedures are treated as outpatient hospital visits <ul style="list-style-type: none"> <li>• Routine X-ray and Routine Diagnostic Tests</li> <li>• CT Scan and MRI</li> <li>• Imaging and Complex Diagnostic Testing</li> </ul>	  <b>\$25 copay</b> <b>\$250 copay</b> <b>\$250 copay</b>
<b>Spinal Manipulation</b> Includes all covered services related to the spinal manipulation. Up to 26 visits per year.	<b>\$50 copay</b>
<b>Temporomandibular Joint Dysfunction</b> <ul style="list-style-type: none"> <li>• TMJ surgery – inpatient hospital</li> <li>• TMJ non-surgical outpatient office visit</li> </ul>	<b>\$1,500 copay</b> <b>\$50 copay</b>
<b>Therapies</b> <ul style="list-style-type: none"> <li>• Physical, occupational and speech – Up to 120 visits per calendar year for all three therapy types combined.</li> <li>• Autism spectrum disorder – Up to 750 hours per calendar year</li> </ul>	<b>\$50 copay</b>  <b>\$25 copay</b>

<sup>1</sup> 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](http://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.

<b>IN-NETWORK PHARMACY</b>	<b>Your Out-of-Pocket Expense RETAIL</b>	<b>Your Out-of-Pocket Expense MAIL ORDER</b>
<b>Tier 0 Essential Health Benefits</b> Includes certain vaccines, contraceptives, smoking cessation medications and more	<b>No Charge</b>	<b>No Charge</b>
<b>Tier 2 Generic</b>	<b>\$10 copay</b>	<b>\$20 copay</b>
<b>Tier 2 Preferred brand</b>	<b>\$30 copay</b>	<b>\$60 copay</b>
<b>Tier 3 Non-preferred brand</b>	<b>\$50 copay</b>	<b>\$150 copay</b>
<b>Tier 4 Specialty drugs</b>	<b>20% coinsurance</b>	<b>Not available</b>
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](http://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 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 Evidence of Coverage (EOC). Once a registered user, you can access the EOC within the secure member portal at [www.ProminenceMember.com](http://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:
<b>What is the overall deductible?</b>	In- <u>Network</u> : \$0 Single / \$0 Single	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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet the <u>deductible</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	In- <u>Network</u> : \$5,000 Single / \$10,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> or call 1-800-863-7515 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.
<b>Do you need a referral to see a specialist?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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	<p><u>Primary Care Provider (PCP)</u> and <u>Specialist copay</u> applies to all services in the Practitioner's office unless the service is also listed on this Summary of Benefits with an additional <u>copay</u>.</p> <p>You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p>
	<u>Specialist</u> visit	\$50 copay per visit	Not Covered	
	<u>Preventive</u> care/ screening/immunization	No charge	Not Covered	
If you have a test		\$25 copay per test.	Not Covered	Some invasive diagnostic procedures are treated as outpatient hospital visits.
	Diagnostic test (x-ray, blood work)	Blood work (Laboratory) - No charge.	Not Covered	
	Imaging (CT scans, MRIs)	\$250 copay per test	Not Covered	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	Complex Diagnostic	\$250 copay per test	Not Covered	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . 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 <a href="http://www.prominencehealthplan.com/">http://www.prominencehealthplan.com/</a></p>	Generic Drugs	\$10 copay per prescription (retail or mail order).	Not Covered	<p><u>Copay</u> 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 <u>copays</u>. Prior authorization (PA) requirements may apply. Visit the formulary on <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a>. 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	\$30 copay per prescription (retail or mail order).	Not Covered	
	Non-Preferred Brand Drugs	\$50 copay per prescription (retail or mail order).	Not Covered	<p><u>Copay</u> applies to 30 day fills. 90 day fills of non-preferred name brand medications at retail or mail order are paid at 3 <u>copays</u>. Prior authorization (PA) requirements may apply. Visit the formulary on <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a>. 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>
	<u>Specialty Drugs</u>	20% Coinsurance	Not Covered	<p>Limit becomes maximum out-of-pocket. Prior authorization (PA) requirements may apply. Visit the formulary on <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a>. 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)	\$250 copay	Not Covered	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	Physician/surgeon fees	Included in above	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 copay per visit	\$500 copay per visit	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 - \$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; <u>claims</u> subject to denial.
	<u>Urgent care</u>	\$50 copay per visit	Not Covered	In and Out-of-Area <u>Urgent Care Services</u> are covered for <u>Medically Necessary Covered Services</u> . Members should call 1-800-863-7515 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)	\$1,500 copay per admit	Not Covered	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> 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 <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . 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)	
If you are pregnant	Office visits	\$25 copay per visit	Not Covered	<p><u>Copay</u> applies to all Obstetrician services associated with the birth. Well Woman prenatal visits are covered without share of cost. <u>Cost Sharing</u> does not apply to <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> or <u>deductible</u> 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.</p>
	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	<u>Home health care</u>	\$25 copay per visit	Not Covered	Maximum 30 visits per calendar year. Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	<u>Rehabilitation services</u>	\$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 <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	<u>Habilitation services</u>	\$50 copay per visit	Not Covered	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	<u>Skilled nursing care</u>	\$1,500 copay per admit	Not Covered	Limited to 100 days per calendar year. Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	<u>Durable medical equipment</u>	Rental - \$25 copay per item Purchase - \$25 copay per item	Not Covered	Prior authorization (PA) requirements apply. Visit <a href="http://www.prominencehealthplan.com">www.prominencehealthplan.com</a> . If PA is not obtained; <u>claims</u> subject to denial.
	<u>Hospice service</u>	No charge	Not Covered	None