Prominence Health Plan

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

## CARSON CITY SCHOOL DISTRICT FREEDOM 6

**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** | **IN-NETWORK[1]: Member pays $1,000 single; $3,000 family**<br>**OUT-OF-NETWORK[1a]: Member pays $2,000 single; $6,000 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** | **IN-NETWORK[1]: Member pays $4,000 single; $8,000 family**<br>**OUT-OF-NETWORK[1a]: Member pays $8,000 single; $16,000 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** | **IN-NETWORK[1]: 20% coinsurance**<br>**OUT-OF-NETWORK[1a]: 50% coinsurance** |

[1] When travelling or living outside the Prominence UHN service areas, you are eligible to receive medical care by a Cigna PPO Network Provider under your In-Network benefits. To find a Cigna Provider, please visit www.myCigna.com [1a] Members who obtain covered benefits from non-plan provider will be responsible for all charges in excess of the Usual and Customary Rate (UCR) charge and you could be responsible for all expenses over and above the UCR. Those charges in excess of the UCR will not be applied to the out-of-pocket maximum. UCR services mean the maximum amount the plan will pay for a covered service.

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### SUMMARY OF BENEFITS - COPAYS

| TYPE OF SERVICE | YOUR OUT-OF-POCKET EXPENSE HEALTHFIRST/ CIGNA IN-NETWORK[1] | YOUR OUT-OF-POCKET EXPENSE PPO OUT-OF-NETWORK[1a] |
|---|---|---|
| **Provider Office Visits**<br>• PriorityCare visit<br>• Primary care provider (PCP) office & telemedicine visit<br>• Specialist office & telemedicine visit<br>*Charges in addition to the office visit copay may include*<br>• In-office surgical procedure<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.* | **$0 copay**<br>**$25 copay**<br>**$50 copay**<br>**$250 copay**<br>**CYD/20% coinsurance** | **Not applicable**<br>**CYD/50% coinsurance**<br>**CYD/50% coinsurance**<br>**CYD/50% coinsurance**<br>**CYD/50% coinsurance** |
| **Teladoc telemedicine**<br>• Primary care<br>• Mental Health | **$0 copay**<br>**$0 copay** | **Not applicable**<br>**Not applicable** |
| **Alternative Medicine**<br>Homeopathy, acupuncture and integrated medicine. $1,500 maximum per calendar year. | **$25 copay** | **CYD/50% coinsurance** |
| **Ambulance Services – Medically necessary only**<br>• Air Ambulance<br>• Ground Ambulance | **$250 copay**<br>**$250 copay** | |
| **Durable Medical Equipment – Rental or purchase**<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 from date of service. | **$25 copay** | **CYD/50% coinsurance** |
| **Emergency Care – Includes surgeon and physician charges**<br>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** | **CYD/50% coinsurance** |

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| TYPE OF SERVICE | YOUR OUT-OF-POCKET EXPENSE HEALTHFIRST/ CIGNA IN-NETWORK[1] | YOUR OUT-OF-POCKET EXPENSE PPO OUT-OF-NETWORK[1a] |
|---|---|---|
| **Hearing Aids**<br>Limit one every three years, from date of service | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| **Home Health Care**<br>Limit to 30 visits per calendar year | **$25 copay** | **CYD/50% coinsurance** |
| **Hospice Care** | **$0 copay per visit** | **CYD/50% coinsurance** |
| **Hospital/Outpatient/Ambulatory Services**<br>Ambulatory and day-surgery series performed in a hospital or other facility. | | |
| • Inpatient | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| • Outpatient surgery | **$250 copay** | **CYD/50% coinsurance** |
| • Observation – No additional copay if transferred from outpatient surgery | **$1,000 copay** | **CYD/50% coinsurance** |
| • Inpatient skilled nursing – Up to 100 days per calendar year | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| • Acute rehabilitation – Up to 60 visits per condition per member per calendar year | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| **Infusion Therapy** | | |
| • Performed and billed by a physician's office or free-standing facility | **$50 copay** | **CYD/50% coinsurance** |
| • Performed and billed by a hospital outpatient facility | **$250 copay** | **CYD/50% coinsurance** |
| • In-network Provider administered specialty infusions | **20% coinsurance** | **CYD/50% coinsurance** |
| **Oncology Infusion** | | |
| • Performed and billed by a physician's office or free-standing facility | **$0 copay** | **CYD/50% coinsurance** |
| • Performed and billed by a hospital outpatient facility | **$250 copay** | **CYD/50% coinsurance** |
| **Kidney Dialysis Services** | **$50 copay** | **CYD/50% coinsurance** |
| **Laboratory** | **No Charge** | **CYD/50% coinsurance** |
| **Pathology** | **No Charge** | **CYD/50% coinsurance** |
| **Mastectomy Reconstructive Services** | | |
| • Inpatient surgery | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| • Outpatient surgery | **$250 copay** | **CYD/50% coinsurance** |

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|---|---|---|
| **Maternity**<br>• Physician: Prenatal care and delivery<br>• Delivery room and well-baby hospital care<br>• Ancillary maternity charges – Including but not limited to fetal non-stress tests and amniocentesis | $200 copay per delivery<br>CYD/$1,000 copay<br>$25 copay | CYD/50% coinsurance<br>CYD/50% coinsurance<br>CYD/50% coinsurance |
| **Medical Nutrition Therapy Counseling**<br>Up to 25 visits per calendar year | $25 copay | CYD/50% coinsurance |
| **Mental Health Services – Severe Mental Illness**<br>• Inpatient<br>• Day treatment program/Outpatient<br>• Outpatient office & telemedicine visit | CYD/$1,000 copay<br>$250 copay<br>$25 copay | CYD/50% coinsurance<br>CYD/50% coinsurance<br>CYD/50% coinsurance |
| **Mental Health Services – General Mental Health**<br>• Teladoc mental health services<br>• Outpatient office & telemedicine visit | $0 copay<br>$25 copay | Not applicable<br>CYD/50% coinsurance |
| **Alcohol and Drug Abuse Services**<br>• Inpatient withdrawal/rehabilitation<br>• Outpatient rehabilitation/day treatment<br>• Outpatient office & telemedicine visit | CYD/$1,000 copay<br>$250 copay<br>$25 copay | CYD/50% coinsurance<br>CYD/50% coinsurance<br>CYD/50% coinsurance |
| **Bariatric Surgery**<br>Includes inpatient or outpatient series. One procedure per lifetime. | CYD/$1,000 copay | CYD/50% coinsurance |
| **Nutritional Supplements**<br>Enteral therapy and parenteral nutrition. Maximum 120 days supply for special food products. | $25 copay | CYD/50% coinsurance |
| **Organ Transplants** | CYD/$1,000 copay | CYD/50% coinsurance |
| **Ostomy Supplies** | $25 copay | CYD/50% coinsurance |

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|---|---|---|
| **Preventive Services [2]**<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** | **CYD/50% coinsurance** |
| • Mammograms - baseline and annual (including 3D and breast ultrasound) | **No Charge** | **CYD/50% coinsurance** |
| • Pap and pelvic exams | **No Charge** | **CYD/50% coinsurance** |
| • Periodic health assessments for hearing and vision for ages 19 and under | **No Charge** | **CYD/50% coinsurance** |
| • BRCA genetic counseling and testing services | **No Charge** | **CYD/50% coinsurance** |
| • Prostate screenings | **No Charge** | **CYD/50% coinsurance** |
| • Well baby and child visits, immunizations/ vaccinations for children through age 17 | **No Charge** | **CYD/50% coinsurance** |
| • Preventive sterilization | **No Charge** | **CYD/50% coinsurance** |
| • Preventive services related to infants, children, and adolescents for evidence informed preventive care and screenings | **No Charge** | **CYD/50% coinsurance** |
| **Prosthetics and Orthotics** | | |
| • Prosthetics and Orthotics – Foot orthotics up to one pair per calendar year | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| • Dental/oral orthotic appliances – TMJ and /or sleep apnea up to one appliance per calendar year | **CYD/$1,000 copay** | **CYD/50% coinsurance** |
| **Radiation Oncology Therapy** | | |
| • Specialist office visit | **$50 copay** | **CYD/50% coinsurance** |
| • Hospital outpatient therapy facility fee | **$250 copay** | **CYD/50% coinsurance** |

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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>• Imaging and Complex Diagnostic Testing | **$25 copay**<br>**$250 copay**<br>**$250 copay** | **CYD/50% coinsurance**<br>**CYD/50% coinsurance** |
| **Spinal Manipulation**<br>Includes all covered services related to the spinal manipulation. Up to 26 visits per year. | **$50 copay** | **CYD/50% coinsurance** |
| **Temporomandibular Joint Dysfunction**<br>• TMJ surgery – inpatient hospital<br>• TMJ non-surgical outpatient office visit | **CYD/$1,000 copay**<br>**$50 copay** | **CYD/50% coinsurance**<br>**CYD/50% coinsurance** |
| **Therapies**<br>• Physical, occupational and speech – Limited to 120 visits per calendar year for all three therapy types combined<br>• Autism spectrum disorder – Up to 750 hours per calendar year | **$50 copay**<br>**$25 copay** | **CYD/50% coinsurance**<br>**CYD/50% coinsurance** |

[1] When travelling or living outside the Prominence UHN service areas, you are eligible to receive medical care by a Cigna PPO Network Provider under your In-Network benefits. To find a Cigna Provider, please visit www.myCigna.com [1a] Members who obtain covered benefits from non-plan provider will be responsible for all charges in excess of the Usual and Customary Rate (UCR) charge and you could be responsible for all expenses over and above the UCR. Those charges in excess of the UCR will not be applied to the out-of-pocket maximum. UCR services mean the maximum amount the plan will pay for a covered service.

[2] 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 1 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 Health Plan HMO member, you can choose from a comprehensive network of providers and services, from primary care providers (PCP), specialists, urgent care clinics, imaging centers, laboratories and more. We encourage you to establish a relationship with your PCP, who can help manage your care and ensure timely receipt of recommended preventive care that may be appropriate. 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.

## CARSON CITY SCHOOL DISTRICT FREEDOM 6

**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.

**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: $1,000 Single / $3,000 Family Out-of-Network: $2,000 Single / $6,000 Family | 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?** | For network providers $4,000 Single / $8,000 Family; Out-of-network providers: $8,000 Single / $16,000 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?** | Referrals may be required based on your geographic location. | To confirm if a referral is needed to see a specialist, please contact Prominence Health Plan Customer Service at the phone number on the back of your member ID card. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay per visit per visit | CYD/50% coinsurance per visit | 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 per visit | CYD/50% coinsurance per visit | |
| | Preventive care/ screening/immunization | No charge | CYD/50% coinsurance | 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<br>Blood work (Laboratory) - No charge. | CYD/50% coinsurance per test<br>Blood work (Laboratory) - CYD/50% coinsurance | Some invasive diagnostic procedures are treated as outpatient hospital visits. |
| | Imaging (CT scans, MRIs) | $250 copay per test | CYD/50% coinsurance per test | Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial. |
| | Complex Diagnostic | $250 copay per test;\ | CYD/50% coinsurance per test | Prior authorization (PA) requirements apply. Visit www.prominencehealthplan.com. If PA is not obtained; claims subject to denial. |



* For 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<br>Network Provider<br>(You will pay the least) | What You Will Pay<br>Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition.**<br><br>**More information about prescription drug coverage is available at** http://www.prominencehealthplan. com/ | Generic Drugs | $10 copay per prescription. | N/A | 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. | N/A | |
| | Non-Preferred Brand Drugs | $50 copay per prescription | N/A | 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 | N/A | Limit becomes maximum out-of-pocket.<br>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. |