

Affordable Health Insurance for Association Members

Choose Association Health Plans for Better Rates!

CAWA members with 2 (unrelated) to 50 full-time employees can now offer insurance coverage for their employees and their families with a high-quality, affordable Association Health Plan from Prominence.

Not an Association member? Enroll at www.cawa.org



Large Group Benefits for Small Employer Groups

- A range of coinsurance options
- Copays for widely used benefits like PCP visits, specialists and lab services
- Statewide HMO open access on all plans & national out-of-state access on certain plans

Employers Have Options... and Flexibility

- Choose from seven health plan options, including HSA-qualified - see reverse
- Affordable monthly premiums
- **Now Available!** Standard COBRA Administration at NO COST to employer clients who elect the service



PARTICIPATING AREAS INCLUDE: Carson City, Clark County, Douglas County, Lyon County, Nye County, Storey County and Washoe County

PROMINENCE ASSOCIATION HEALTH PLANS

Our Association Health Plans allow small employers to join as one entity to purchase the type of coverage that is traditionally available to large group employers. This results in less expensive and richer health plan options that can then be passed along to the employee.

Plan Highlights You Don't Want to Miss!

- **wellPORTAL Primary Care Provider Network** - Members in southern Nevada can earn up to \$120 annually for getting the care they need from the region's top doctors.
- **National Network** - Prominence has partnered with Cigna to allow access to a national network for use outside of Nevada for members enrolled in either a POS or PPO health plan.
- **Teladoc** - 24/7 care via telephone or video from licensed physicians, psychiatrists, and counselors for a \$0 cost share. Note, High Deductible Health Plans are subject to deductible first and benefits will be rendered at the contractual service rate.

Call Prominence today at 855-400-5126 or ask your broker about our Association Health Plans!



Prominence
Health Plan

REV OCT22



2023 BENEFIT OVERVIEW

Statewide HMO with no specialist referrals for members; benefits listed below are in-network;

* indicates plans with national network access outside Nevada

PLANS RENEW JANUARY 1, 2024

GROUPS CAN CHOOSE UP TO THREE ASSOCIATION HEALTH PLANS TO ENROLL							
In-Network Benefits	HMO 2000	HMO 7000	POS 1000* HMO/PPO	POS 3000* HMO/PPO	NEW PLAN! POS 5000* HMO/PPO	POS 7500 HMO/PPO*	NEW PLAN! PPO HDHP 3000* ¹
Calendar Year Deductible (CYD)							
Single	\$2,000	\$7,000	\$1,000/\$1,500	\$3,000/\$3,500	\$5,000/\$5,500	\$7,500/\$7,500	\$3,000
Family	\$6,000	\$14,000	\$2,000/\$3,000	\$6,000/\$7,000	\$10,000/\$11,000	\$15,000/\$15,000	\$6,000
Coinsurance							
	20%	50%	20%	30%	30%	30%	10%
Out-of-Pocket Maximum							
Single	\$6,850	\$8,150	\$4,000/\$6,500	\$6,850/\$8,150	\$7,300/\$8,000	\$8,550/\$8,550	\$5,000
Family	\$13,700	\$16,300	\$8,000/\$13,000	\$13,700/\$16,300	\$14,600/\$16,000	\$17,100/\$17,100	\$10,000
Provider Office Visits							
Telemedicine - Teladoc	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	CYD/\$0 copay
Primary Care Provider (PCP)	\$25 copay	\$35 copay	\$15/\$30 copay	\$25/\$50 copay	\$0 copay	\$30/\$60 copay	CYD/10%
wellPortal Primary Care	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$30/\$60	\$0 copay	CYD/10%
Specialist	\$50 copay	\$70 copay	\$30/\$60 copay	\$50/\$80 copay	\$60/\$90 copay	\$60/\$90 copay	CYD/10%
Emergency/Urgent Care							
Ambulance – Ground & Air	\$250 copay per trip	\$1,000 copay per trip	\$250 copay per trip	\$500 copay per trip	\$1,000 copay per trip	\$1,500 copay per trip	CYD/10%
Emergency Room	CYD	\$1,000 copay	\$500 copay	CYD/30%	\$1,000 copay	\$1,500 copay	CYD/10%
Urgent Care	\$50 copay	\$70 copay	\$50/\$100 copay	\$50/\$100 copay	\$50/\$100 copay	\$50/\$100 copay	CYD/10%
Hospital/Facility/Surgical							
Outpatient Surgical	\$250 copay	\$1,000 copay	\$250 copay/ CYD 20%	\$500 copay/ CYD 30%	\$1,000 copay/ CYD 30%	\$1,500 copay/ CYD 30%	CYD/10%
Inpatient Hospital	CYD/\$1,000 copay	CYD/50%	CYD \$1,000/ CYD 20%	CYD \$2,000/ CYD 30%	CYD 30%/ CYD 30%	CYD 30%/ CYD 30%	CYD/10%
Pharmacy							
FDA-approved Preventive	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Generic/Brand/Non-Brand	\$15/\$40/\$60	\$25/\$50/\$75	\$25/\$50/\$75	\$25/\$50/\$75	\$25/\$50/\$75	\$25/\$50/\$75	CYD/10%
Specialty	20%	20%	20%	20%	20%	20%	CYD/10%
Radiology							
Routine X-Ray & Diagnostic	\$25 copay	\$35 copay	\$15/\$30 copay	\$25/\$50 copay	\$30/\$60 copay	\$30/\$60 copay	CYD/10%
CT Scan & MRI	\$250 copay	\$1,000 copay	\$250 copay/ CYD 20%	\$500 copay/ CYD 30%	\$1,000 copay/ CYD 30%	\$1,500 copay/ CYD 30%	CYD/10%
Complex Diagnostic	CYD/20%	\$1,000 copay	\$250 copay/ CYD 20%	CYD 30%	\$1,000 copay/ CYD 30%	\$1,500 copay/ CYD 30%	CYD/10%
Maternity							
Prenatal Care & Delivery	\$200 copay per delivery	\$200 copay per delivery	\$200 copay/CYD 20% per delivery	\$250 copay/CYD 30% per delivery	\$200 copay/CYD 30% per delivery	\$200 copay/ CYD 30%	CYD/10%
Delivery Room & Well-baby Hospital	CYD/\$1,000 copay	CYD/50%	CYD \$1,000 copay/ CYD 20%	CYD \$2,000 copay/ CYD 30%	CYD 30%/ CYD 30%	CYD 30%/ CYD 30%	CYD/10%
Mental Health/Alcohol & Drug Abuse Services							
Inpatient	CYD/\$1,000 copay	CYD/50%	CYD \$1,000/ CYD 20%	CYD \$2,000/ CYD 30%	CYD 30%/ CYD 30%	CYD 30%/ CYD 30%	CYD/10%
Outpatient	\$250 copay	\$1,000 copay	\$250 copay/ CYD 20%	\$500 copay/ CYD 30%	\$1,000 copay/ CYD 30%	\$1,500 copay/ CYD 30%	CYD/10%
Office Visit	\$25 copay	\$35 copay	\$15/\$30 copay	\$25/\$50 copay	\$30/\$60 copay	\$30/\$60 copay	CYD/10%
Lab and Pathology							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	CYD/10%
Pediatric Dental & Vision - Diagnostic and Preventive (up to age 19)							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

¹ High Deductible Health Plans are subject to deductible first and benefits will be rendered at the contractual rate based upon type of service.



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California Automotive Wholesalers Association Dental and Vision Plans

Dental Care Services	Premier Choice Network (PCN)	PPO	Out of Network	DHMO 400
Deductible (Applies to Basic and Major)	\$25	\$50	\$50	\$0
Class I Oral Exams, Prophylaxis (Cleanings), Fluoride, X-rays	100%	100%	100%	Copays: \$0–\$80.00
Class II Emergency, Space Maintainers, Fillings, Oral Surgery, Sealants, Periodontics, Endodontics (Root Canal)	90%	80%	80%	Copays: \$8.00–\$365.00
Class III Inlays, Onlays, Crowns, Bridges, Dentures, Repairs	60%	50%	50%	Copays: \$200.00–\$350.00
Calendar Year Maximum	Plus Plan 6: \$1,500 (MAC). Plus Plan 21: \$2,000 (MAC)			Unlimited
Ortho Lifetime Maximum Child(ren) only	50% \$1,500			Copay Child: \$2,250 Copay Adult: \$2,500
Waiting Period	12 months for major services for groups with fewer than 10 enrollees and no prior coverage			N/A

Plus Plan 6 – MAC
with Premier Advantage where available
\$1,500 Calendar Maximum

Region 1: 890, 891 Employee participation 65%			
		No Child Ortho	\$1,500 Child Ortho
3 to 99 EEs	EE	\$26.84	\$26.84
	ES	\$54.48	\$54.48
	EC	\$65.72	\$75.60
	EF	\$102.52	\$114.79

Plus Plan 21 – MAC
with Premier Advantage where available
\$2,000 Calendar Maximum

Region 1: 890, 891 Employee participation 65%			
		No Child Ortho	\$1,500 Child Ortho
3 to 99 EEs	EE	\$28.72	\$28.72
	ES	\$58.32	\$58.32
	EC	\$68.17	\$78.05
	EF	\$107.42	\$119.69

DHMO 400

All Regions, All Contributions		
2 to 99 EEs	EE	\$15.62
	ES	\$31.23
	EC	\$42.46
	EF	\$64.39

Region 2: 893, 894, 895, 897, 898 Employee participation 65%			
		No Child Ortho	\$1,500 Child Ortho
3 to 99 EEs	EE	\$30.72	\$30.72
	ES	\$62.35	\$62.35
	EC	\$74.73	\$84.61
	EF	\$116.73	\$129.00

Region 2: 893, 894, 895, 897, 898 Employee participation 65%			
		No Child Ortho	\$1,500 Child Ortho
3 to 99 EEs	EE	\$32.89	\$32.89
	ES	\$67.79	\$67.79
	EC	\$77.90	\$87.78
	EF	\$122.37	\$134.64

Plan summary available upon request. Seventy-five percent of all enrolled employees must reside in Nevada.

*For Plus Plans: Charges in excess of our maximum covered fee will not be considered covered under this policy.

**Premier Access does not guarantee all services can be rendered by a contracted PCN or PPO provider. You may be subject to a deductible and coinsurance for an out-of-network specialist.

Vision Care Services	In-Network	Out-of-Network	
Vision Examination	Covered in full after exam copay	Up to \$35	
Contact Lens Fitting	Standard – Up to \$50 copay Premium – Up to \$75 copay	N/A N/A	Participating Walmart and Sam's Club locations cover frames up to a \$68 retail value. Participating Costco locations cover frames up to a \$74.99 retail value. No discounts apply.
Frame Allowance*	\$130 retail allowance + up to 20% discount	Up to \$45	Values provided may be more or less, depending on the provider's retail pricing.
Standard Spectacle Lenses			Discounts are not insured benefits.
Single Vision	Covered in full after materials copay	Up to \$25	
Bifocal	Covered in full after materials copay	Up to \$40	
Trifocal	Covered in full after materials copay	Up to \$50	
Lenticular	Covered in full after materials copay	Up to \$80	
Progressives	\$50 allowance + 20% discount	Up to \$40	
Youth Polycarbonate	Covered in full after materials copay	Up to \$10	
Other Lens Options†	Avësis Preferred Pricing	N/A	
Contact Lenses[§] (in lieu of frame and spectacle lenses)			‡Prior authorization is required for medically necessary contacts.
Elective	\$130 allowance	Up to \$110	
Medically Necessary	Covered in full	Up to \$250	
LASIK	Provider discount up to 25% \$150 one-time/lifetime allowance	Up to \$150	

Copays	
Vision Examination	\$10
Materials	\$25

Frequency	
Eye Examination	12 Months
Lenses or contact lenses	12 Months
Frame	24 Months

Monthly Rates Employee Participation 65%	
Employee Only	\$5.79
Employee and Spouse	\$10.13
Employee and Child(ren)	\$12.15
Employee and Family	\$15.05

Limitations and Exclusions:

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations:

This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avësis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions:

There are no benefits under the plan for professional services or materials connected with and arising from

1. Orthoptics or vision training;
2. Subnormal vision aids and any supplemental testing, aniseikonic lenses;
3. Plano (non-prescription) lenses, sunglasses;
4. Two pair of glasses in lieu of bifocal lenses;
5. Any medical or surgical treatment of eye or supporting structures;
6. Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services;
7. Any eye examination or corrective eyewear required by an employer as a condition of employment and safety eyewear;
8. Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governmental agency whether Federal, State, or subdivision thereof.
9. Services or materials provided by any other group benefit plan providing vision care.

Refractive Surgery Vision Benefit Exclusions:

Benefits are not payable for any of the following

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
2. Medical or surgical procedures, services, or treatments:
 - a. not specifically covered under this Rider;
 - b. provided free of charge in the absence of insurance
 - c. payable under any Workers' Compensation law or similar statutory authority
 - d. payable under governmental plan or program, whether Federal, state, or subdivisions thereof.

Termination Provisions:

Coverage will end on the earliest of: the date the policy ends, the date the employee's employment ends, or the date the employee is no longer eligible.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avësis is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart locations. Members may not use their contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.



Premium is subject to adjustment in the event of changes in benefits, contributions, or the number of eligible employees, or any future additional tax, fee or assessment imposed by the Federal or State governments with associated administrative costs and expenses.

Avësis E-Series Vision Plan is underwritten by Fidelity Security Life Insurance Company, Kansas City, MO. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Policy Form #VC-16.

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Premier Access
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www.premierlife.com

Premier Advantage gives you the freedom to switch back and forth between each plan.



DHMO

No Calendar Year Maximum

No Waiting Periods

Little or No Copayment

Panel of Dentists

*Orthodontia Coverage for
Adults & Children*

PPO

*Choice of any Licensed Dentist,
Including Specialists*

*Maximize Your Benefits
With a PCN Provider*

*No Referral Required for
Specialty Services*

If you are in the middle of treatment, you are required to complete treatment in progress prior to electing to switch to a new plan.

If you would like to change your benefit plan, please contact Customer Service at:

TEL 888.715.0760 (toll free)

EMAIL CUSTOMERSERVICE@PREMIERLIFE.COM

WEB WWW.PREMIERLIFE.COM

Note: The information provided here is intended only to show the highlights of the dental plan and is not a complete description of the plan. The plan is governed by the official plan document and/or insurance contract where applicable. If there is a discrepancy between the information provided here and the plan document and/or insurance contract, the plan document and/or insurance contract will prevail. Premier Access PPO benefits are underwritten by Premier Access Insurance Company, Sacramento, CA. "Dental HMO" is used to refer to product designs that include "Specialized Health Care Service Plans" in California, by Access Dental Plan, a California Corporation.