SCHEDULE OF BENEFITS
PROMINENCE HEALTHFIRST
LARGE GROUP EMPLOYER PLAN

PROMINENCE AHP POS 6

This disclosure statement provides only a brief description of some important features and limitations of Your Plan. 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. See your EOC for definitions of capitalized terms.

If you have questions about this Schedule of Benefits, please call Prominence Customer Service at 800-863-7515 or TTY Operator Assistance at 800-326-6868. ProminenceHealthPlan.com also serves as an important resource and includes information about Provider Directories, Urgent Care Emergency care locations and more.

CALENDAR YEAR DEDUCTIBLE (CYD)
ANNUAL OUT-OF-POCKET MAXIMUMS

CALENDAR YEAR DEDUCTIBLE	**HMO IN-NETWORK: Member pays $1,250 single; $2,500 family** **PPO IN-NETWORK: Member pays $2,000 single; $4,000 family** **OUT-OF-NETWORK (1): Member pays $3,000 single; $6,000 family**
The 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 and Coinsurance do not count towards the Deductible.	
COINSURANCE	**HMO IN-NETWORK: 20% Coinsurance** **PPO IN-NETWORK: 20% Coinsurance** **OUT-OF-NETWORK: 50% Coinsurance**
Coinsurance is the percentage of the Allowed Amount that a Member must pay a Provider for Covered Services.	

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ANNUAL OUT-OF-POCKET MAXIMUM	**HMO IN-NETWORK: Member pays $9,200 single; $18,400 family** **PPO IN-NETWORK: Member pays $9,200 single; $18,400 family** **OUT-OF-NETWORK [1]: Member pays $18,400 single; $36,000 family**
The Out-of-Pocket Maximum is the combined total expense paid by a Member in Coinsurance, Copayments and Deductible for all Covered Services in a Calendar Year. The Out-of-Pocket Maximum does not include: • Expenses for Covered Services in excess of the Allowed Amount; • Expenses for which no benefits are payable by the Plan; and • Expenses which become the Member's responsibility for failure to comply with the Utilization Management Program or Prior Authorization requirements.	

[1] Except during Emergencies, Members who obtain Covered Services from an Out-of-Network Provider will be responsible for all charges in excess of the Usual, Customary and Reasonable (UCR) rate. Those charges in excess of the UCR rate will not be applied to the Out-of-Pocket Maximum.

[1a] When traveling or living outside the Prominence Service Area, you are eligible to receive Covered Services by a Cigna PPO Network Provider. To find a Cigna Provider, please visit myCigna.com.

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE		
	HMO IN-NETWORK[1a]	PPO IN-NETWORK[1]	OUT-OF-NETWORK[1a]
Provider Office Visits			
• wellPORTAL primary care (available in Southern Nevada only)	**$0 Copay**	**Not Applicable**	**Not Applicable**
• Primary Care Provider (PCP) office & Telemedicine visits	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
• Specialist office & Telemedicine visits	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
• Mental health outpatient office & Telemedicine visits	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
• Alcohol and drug abuse treatment office visits	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
Charges in addition to the office visit copay may include:			
• In-office surgical procedure	**$250 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• In-office injectable (excluding specialty drugs)	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
There may be additional changes for other services in the provider's office.			
Teladoc Virtual Visits at (800)TELADOC or teladoc.com			
• Primary Care	**$0 Copay**	**Not Applicable**	**Not Applicable**
• Behavioral Health	**$0 Copay**	**Not Applicable**	**Not Applicable**
Preventive Services - See Your EOC for a full list of Preventive Services	**No Charge**	**No Charge**	**CYD/50% Coinsurance**
Urgent Care	**$30 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
Laboratory / Pathology	**$0 Copay**	**$0 Copay**	**CYD/50% Coinsurance**

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PHARMACY SERVICES Diabetic supplies are obtainable from a pharmacy (including needles, syringes, test strips, lancets and alcohol swabs available at retail or mail order).		
	IN-NETWORK	**OUT-OF-NETWORK**
Pharmacy Tier 0 - Preventive Includes certain vaccines, contraceptives, smoking cessation medications and more	**No Charge**	**Not Covered**
Pharmacy Tier 1 - Generic		
• Retail	**$25 Copay**	**Not Covered**
• Mail Order (90-day supply)	**$50 Copay**	**Not Covered**
Pharmacy Tier 2 - Preferred Brand		
• Retail	**$50 Copay**	**Not Covered**
• Mail Order (90-day supply)	**$100 Copay**	**Not Covered**
Pharmacy Tier 3 - Non-preferred Brand		
• Retail	**$75 Copay**	**Not Covered**
• Mail Order (90-day supply)	**$225 Copay**	**Not Covered**
Pharmacy Tier 4 - Specialty Drugs		
• Retail	**20% Coinsurance**	**Not Covered**
• Mail Order (90-day supply)	**Not Available**	**Not Covered**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE		
	HMO IN-NETWORK[1a]	PPO IN-NETWORK[1]	OUT-OF-NETWORK[1a]
Alternative Medicine Homeopathy, acupuncture and integrated medicine; $1,500 maximum	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
Ambulance Services - Medically necessary only			
• Air Ambulance		**$250 Copay**	
• Ground Ambulance		**$250 Copay**	
Durable Medical Equipment - Rental or purchase	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
Emergency Care - Includes surgeon and physician charges The Copayment is waived when the Member is admitted as an inpatient directly from the Emergency room. Services received in an Emergency room for a non-Emergency condition are not a covered benefit.		**$500 Copay**	
Hearing Aids - Limit one set every three years	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Home Health Care Limited to 30 visits per calendar year	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
Hospice Care	**$0 Copay**	**$0 Copay**	**CYD/50% Coinsurance**
Hospital/Outpatient/Ambulatory Services Ambulatory and day-surgery series performed in a hospital or other			
• Outpatient surgery	**$250 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Inpatient surgery/admit	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Observation - No additional copay if transferred from outpatient surgery	**$500 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Inpatient skilled nursing - Up to 100 days per year	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Acute rehabilitation - Up to 60 visits per condition per year	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**

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	HMO IN-NETWORK[1a]	PPO IN-NETWORK[1]	OUT-OF-NETWORK[1a]
Infusion Therapy • Performed and billed by a physician's office or free-standing facility • Performed and billed by a hospital outpatient facility • In-network specialty infusions	**$15 Copay** **$250 Copay** **20% Coinsurance**	**$30 Copay** **CYD/20% Coinsurance** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance** **CYD/50% Coinsurance**
Oncology Infusion Therapy Drugs for select oncology treatments • Performed and billed by a physician's office or free-standing facility • Performed and billed by a hospital outpatient facility	**$0 Copay** **$250 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**
Kidney Dialysis Services	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
Mastectomy Reconstruction Services • Outpatient surgery • Inpatient surgery	**$250 Copay** **CYD/$1,000 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**

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	HMO IN-NETWORK[1a]	PPO IN-NETWORK[1]	OUT-OF-NETWORK[1a]
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/delivery** **CYD/$1,000 Copay** **$15 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance** **$30 Copay**	**CYD/50% Coinsurance** **CYD/50% Coinsurance** **CYD/50% Coinsurance**
Medical Nutrition Therapy Counseling - Up to 25 visits per year	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
Mental Health Services - Severe Mental Illness • Day treatment program/Outpatient • Inpatient	**$250 Copay** **CYD/$1,000 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**
Alcohol and Drug Abuse Services • Outpatient rehabilitation/day treatment • Inpatient withdrawal/rehabilitation	**$250 Copay** **CYD/$1,000 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**
Bariatric Surgery - Inpatient or outpatient; one procedure per lifetime	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Nutritional Supplements - Enteral formulas and parenteral nutrition; maximum 120 days supply	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
Organ Transplants	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Ostomy Supplies	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
Prosthetics and Orthotics • Prosthetics and Orthotics - Foot orthotics up to two pair per year • Dental/oral orthotic appliances - TMJ and/or sleep apnea up to one appliance per year • Post-cataract services - Up to one pair of basic frames and lenses per year	**CYD/$1,000 Copay** **CYD/$1,000 Copay** **$100 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance** **CYD/40% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance** **CYD/50% Coinsurance**

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	HMO IN-NETWORK[1a]	PPO IN-NETWORK[1]	OUT-OF-NETWORK[1a]
Radiation Oncology Therapy			
• Specialist office visit	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
• Hospital outpatient therapy facility fee	**$250 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Radiology and Diagnostic Services Some invasive diagnostic procedures are treated as outpatient hospital			
• Routine X-ray and Routine Diagnostic Tests	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**
• CT Scan and MRI	**$250 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Imaging and Complex Diagnostic Testing	**$250 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Spinal Manipulation - Up to 26 visits per year	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
Temporomandibular Joint Dysfunction			
• TMJ non-surgical outpatient office visit	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
• TMJ surgery - Inpatient hospital	**CYD/$1,000 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Therapies			
• Physical, occupational and speech			
◦ Habilitative - Up to 120 visits per year	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
◦ Rehabilitative - Up to 120 visits per year	**$30 Copay**	**$60 Copay**	**CYD/50% Coinsurance**
• Autism spectrum disorder - Up to 1,500 hours per year	**$15 Copay**	**$30 Copay**	**CYD/50% Coinsurance**

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Pediatric Dental • Diagnostic and preventive services • Basic restorative procedures • Major restorative procedures • Orthodontia	**No Charge** **CYD/20% Coinsurance** **CYD/40% Coinsurance** **CYD/40% Coinsurance**	**No Charge** **CYD/20% Coinsurance** **CYD/40% Coinsurance** **CYD/40% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance** **CYD/50% Coinsurance** **CYD/50% Coinsurance**
Pediatric Vision • Routine eye exam - One per year • Glasses - One pair of basic frames and lenses per year	**No Charge** **No Charge**	**CYD/20% Coinsurance** **CYD/40% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**
ALL OTHER HOSPITAL AND OUTPATIENT SERVICES	**$250 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**

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Prescription Drug Coverage

Visit 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 the Prominence Pharmacy Help Desk at (833)775-MEDS (6337).

Prior authorization

Prior Authorization is the process in which a Provider must justify the need for delivering a Covered Service or medication to a Member and obtain approval from Prominence before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment: payment is dependent upon eligibility at the time Covered Service is received. For a complete list of services requiring an authorization, or to confirm if Prior Authorization has been obtained, visit Your Member Portal at ProminenceMember.com or call Prominence Customer Services at (800)863-7515.

Language Translation Services

This information is available for free in other languages. Please call Customer Service at (775)770-9310 / (800)863-7515 (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 (775)770-9310 / (800)863-7515 (TTY: 711) para mas información.