

**SCHEDULE OF BENEFITS
PROMINENCE HEALTHFIRST
SMALL GROUP EMPLOYER PLAN**

PROMINENCE POS 9 GOLD

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 \$2,500 single; \$5,000 family PPO IN-NETWORK: Member pays \$5,000 single; \$10,000 family OUT-OF-NETWORK ⁽¹⁾: Member pays \$10,000 single; \$20,000 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: 10% 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 \$7,000 single; \$14,000 family PPO IN-NETWORK: Member pays \$9,000 single; \$18,000 family OUT-OF-NETWORK ⁽¹⁾: Member pays \$14,000 single; \$28,000 family
<p>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:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> Primary Care Provider (PCP) office & Telemedicine visits Specialist office & Telemedicine visits Mental health outpatient office & Telemedicine visits Alcohol and drug abuse treatment office visits <i>Charges in addition to the office visit copay may include:</i> <ul style="list-style-type: none"> In-office surgical procedure In-office injectable (excluding specialty drugs) <i>There may be additional charges for other services in the provider's office.</i>	\$25 Copay \$60 Copay \$25 Copay \$25 Copay CYD/10% Coinsurance CYD/ 10% Coinsurance	\$35 Copay \$70 Copay \$35 Copay \$35 Copay CYD/20% Coinsurance CYD/20% Coinsurance	CYD/50% Coinsurance CYD/50% Coinsurance CYD/50% Coinsurance CYD/50% Coinsurance CYD/50% Coinsurance CYD/50% Coinsurance
PriorityCare <ul style="list-style-type: none"> wellPORTAL primary care (Available only in Southern Nevada) 	\$0 Copay	Not Applicable	Not Applicable
Teladoc Virtual Visits at (800)TELADOC or teladoc.com <ul style="list-style-type: none"> Primary Care Behavioral Health 	\$0 Copay \$0 Copay	Not Applicable Not Applicable	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	\$50 Copay	\$100 Copay	CYD/50% Coinsurance
Laboratory / Pathology	\$35 Copay	CYD/20% Coinsurance	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 <ul style="list-style-type: none"> Retail Mail Order (90-day supply) 	\$0 Copay \$0 Copay	Not Covered Not Covered
Pharmacy Tier 2 - Preferred Brand <ul style="list-style-type: none"> Retail Mail Order (90-day supply) 	\$50 Copay \$100 Copay	Not Covered Not Covered
Pharmacy Tier 3 - Non-preferred Brand <ul style="list-style-type: none"> Retail Mail Order (90-day supply) 	CYD/ 10% Coinsurance CYD/10% Coinsurance	Not Covered Not Covered
Pharmacy Tier 4 - Specialty Drugs <ul style="list-style-type: none"> Retail Mail Order (90-day supply) 	CYD/ 10% Coinsurance Not Available	Not Covered Not Covered

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	HMO IN-NETWORK ^{1a}	PPO IN-NETWORK ¹	OUT-OF-NETWORK ^{1a}
Alternative Medicine Homeopathy, acupuncture and integrated medicine; \$1,500 maximum	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
Ambulance Services - Medically necessary only <ul style="list-style-type: none"> Air Ambulance Ground Ambulance 	CYD/10% Coinsurance CYD/10% Coinsurance		
Durable Medical Equipment - Rental or purchase	\$60 Copay	\$80 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.	CYD/ 10% Coinsurance		
Hearing Aids - Limit one set every three years	CYD/10% Coinsurance	\$70 Copay	CYD/50% Coinsurance
Home Health Care Limited to 30 visits per calendar year	\$25 Copay	\$40 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 <ul style="list-style-type: none"> Outpatient surgery Inpatient surgery/admit Observation - No additional copay if transferred from outpatient surgery Inpatient skilled nursing - Up to 100 days per year Acute rehabilitation - Up to 60 visits per condition per year 	CYD/10% Coinsurance CYD/10% Coinsurance CYD/10% Coinsurance CYD/10% Coinsurance CYD/10% Coinsurance	CYD/20% Coinsurance CYD/20% Coinsurance CYD/20% Coinsurance CYD/20% Coinsurance CYD/20% Coinsurance	CYD/50% Coinsurance CYD/50% 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}
Infertility Treatment Services Office visit evaluation - please refer to the applicable surgical procedure copay and/or Coinsurance amount for any surgical infertility procedures	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Infusion Therapy <ul style="list-style-type: none"> Performed and billed by a physician's office or free-standing facility Performed and billed by a hospital outpatient facility In-network specialty infusions 	\$60 Copay CYD/10% Coinsurance \$25 Copay	\$70 Copay CYD/20% Coinsurance \$40 Copay	CYD/50% Coinsurance CYD/50% Coinsurance Not Applicable
Oncology Infusion Therapy Drugs for select oncology treatments <ul style="list-style-type: none"> Performed and billed by a physician's office or free-standing facility Performed and billed by a hospital outpatient facility 	\$0 Copay CYD/10% Coinsurance	\$0 Copay CYD/20% Coinsurance	CYD/50% Coinsurance CYD/50% Coinsurance
Kidney Dialysis Services	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
Mastectomy Reconstruction Services <ul style="list-style-type: none"> Outpatient surgery Inpatient surgery 	CYD/10% Coinsurance CYD/10% Coinsurance	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 <ul style="list-style-type: none"> 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/10% Coinsurance \$60 Copay	CYD/20% Coinsurance CYD/20% Coinsurance \$70 Copay	CYD/50% Coinsurance CYD/50% Coinsurance CYD/50% Coinsurance
Medical Nutrition Therapy Counseling - Up to 25 visits per year	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
Mental Health Services - Severe Mental Illness <ul style="list-style-type: none"> Day treatment program/Outpatient Inpatient 	CYD/10% Coinsurance CYD/10% Coinsurance	CYD/20% Coinsurance CYD/20% Coinsurance	CYD/50% Coinsurance CYD/50% Coinsurance
Alcohol and Drug Abuse Services <ul style="list-style-type: none"> Inpatient withdrawal/rehabilitation Outpatient rehabilitation/day treatment 	CYD/10% Coinsurance CYD/10% Coinsurance	CYD/20% Coinsurance CYD/20% Coinsurance	CYD/50% Coinsurance CYD/50% Coinsurance
Bariatric Surgery - Inpatient or outpatient; one procedure per lifetime	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Nutritional Supplements - Enteral formulas and parenteral nutrition; maximum 120 days supply	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Organ Transplants	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Ostomy Supplies	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Prosthetics and Orthotics <ul style="list-style-type: none"> 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/10% Coinsurance CYD/10% Coinsurance CYD/10% Coinsurance	CYD/20% Coinsurance CYD/20% Coinsurance CYD/20% 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 <ul style="list-style-type: none"> Specialist office visit Hospital outpatient therapy facility fee 	\$60 Copay CYD/10% Coinsurance	\$70 Copay CYD/20% Coinsurance	CYD/50% Coinsurance CYD/50% Coinsurance
Radiology and Diagnostic Services Some invasive diagnostic procedures are treated as outpatient hospital <ul style="list-style-type: none"> Routine X-ray and Routine Diagnostic Tests CT Scan and MRI Imaging and Complex Diagnostic Testing 	\$60 Copay CYD/10% Coinsurance CYD/10% Coinsurance	\$70 Copay CYD/20% Coinsurance CYD/20% 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}
Spinal Manipulation - Up to 26 visits per year	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
Temporomandibular Joint Dysfunction			
• TMJ non-surgical outpatient office visit	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
• TMJ surgery - Inpatient hospital	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Therapies			
• Physical, occupational and speech			
• • Habilitative - Up to 120 visits per year	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
• • Rehabilitative - Up to 120 visits per year	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
• Autism spectrum disorder - Up to 1,500 hours per year	\$60 Copay	\$70 Copay	CYD/50% Coinsurance
Pediatric Dental			
• Diagnostic and preventive services	No Charge	No Charge	CYD/50% Coinsurance
• Basic restorative procedures	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
• Major restorative procedures	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
• Orthodontia	CYD/10% Coinsurance	CYD/20% Coinsurance	CYD/50% Coinsurance
Pediatric Vision			
• Routine eye exam - One per year	No Charge	No Charge	CYD/50% Coinsurance
• Glasses - One pair of basic frames and lenses per year	No Charge	No Charge	CYD/50% Coinsurance
ALL OTHER HOSPITAL AND OUTPATIENT SERVICES	CYD/10% Coinsurance	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 información 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 más información.