

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

Nevada Hotel & Lodging Association HMO 3000

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	Member pays \$3,000 single; \$9,000 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	30% Coinsurance
Coinsurance is the percentage of the Allowed Amount that a Member must pay a Provider for Covered Services.	
ANNUAL OUT-OF-POCKET MAXIMUM	Member pays \$7,100 single; \$14,200 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:	
<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. 	

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
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>	\$30 Copay \$60 Copay \$30 Copay \$30 Copay CYD/30% Coinsurance 20% Coinsurance
Teladoc Virtual Visits at (800)TELADOC or teladoc.com <ul style="list-style-type: none"> • Primary Care • Behavioral Health 	\$0 Copay \$0 Copay
Preventive Services - See Your EOC for a full list of Preventive Services	No Charge
Urgent Care	\$50 Copay
Laboratory / Pathology	No Charge
PHARMACY SERVICES	
Diabetic supplies are obtainable from a pharmacy (including needles, syringes, test strips, lancets and alcohol swabs available at retail or mail order).	
Pharmacy Tier 0 - Preventive Includes certain vaccines, contraceptives, smoking cessation medications and more	No Charge
Pharmacy Tier 1 - Generic <ul style="list-style-type: none"> • Retail • Mail Order (90-day supply) 	\$25 Copay \$50 Copay
Pharmacy Tier 2 - Preferred Brand <ul style="list-style-type: none"> • Retail • Mail Order (90-day supply) 	\$50 Copay \$100 Copay
Pharmacy Tier 3 - Non-preferred Brand <ul style="list-style-type: none"> • Retail • Mail Order (90-day supply) 	\$75 Copay \$225 Copay
Pharmacy Tier 4 - Specialty Drugs <ul style="list-style-type: none"> • Retail • Mail Order (90-day supply) 	20% Coinsurance Not Available

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Alternative Medicine Homeopathy, acupuncture and integrated medicine; \$1,500 maximum	\$60 Copay
Ambulance Services - Medically necessary only <ul style="list-style-type: none"> • Air Ambulance • Ground Ambulance 	CYD/30% Coinsurance CYD/30% Coinsurance
Durable Medical Equipment - Rental or purchase	CYD/30% 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	30% Coinsurance
Home Health Care Limited to 30 visits per calendar year	CYD/30% coinsurance
Hospice Care	\$0 Copay
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 	\$1,000 Copay CYD/30% Coinsurance \$1,000 Copay CYD/30% Coinsurance CYD/30% 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 	30% Coinsurance CYD/30% Coinsurance 20% Coinsurance

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Oncology Infusion Therapy Drugs for select oncology treatments For a complete list of covered services, visit ProminenceHealthPlan.com/SelectOncologyInfusion <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/30% Coinsurance
Kidney Dialysis Services	\$60 Copay
Mastectomy Reconstruction Services <ul style="list-style-type: none"> • Outpatient surgery • Inpatient surgery 	\$1,000 Copay CYD/30% Coinsurance
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/30% Coinsurance \$30 Copay
Medical Nutrition Therapy Counseling - Up to 25 visits per year	\$30 Copay
Mental Health Services - Severe Mental Illness <ul style="list-style-type: none"> • Day treatment program/Outpatient • Inpatient 	\$1,000 Copay CYD/30% Coinsurance
Alcohol and Drug Abuse Services <ul style="list-style-type: none"> • Inpatient withdrawal/rehabilitation • Outpatient rehabilitation/day treatment 	CYD/30% Coinsurance \$1,000 Copay
Bariatric Surgery - Inpatient or outpatient; one procedure per lifetime	CYD/30% Coinsurance
Nutritional Supplements - Enteral formulas and parenteral nutrition; maximum 120 days supply	CYD/30% Coinsurance
Organ Transplants	CYD/30% Coinsurance
Ostomy Supplies	CYD/30% 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/30% Coinsurance CYD/30% Coinsurance \$100 Copay

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Radiation Oncology Therapy <ul style="list-style-type: none"> • Specialist office visit • Hospital outpatient therapy facility fee 	\$60 Copay \$1,000 Copay
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 Test • CT Scan and MRI • Imaging and Complex Diagnostic Testing 	\$30 Copay \$250 Copay \$350 Copay
Spinal Manipulation - Up to 26 visits per year	\$60 Copay
Temporomandibular Joint Dysfunction <ul style="list-style-type: none"> • TMJ non-surgical outpatient office visit • TMJ surgery - Inpatient hospital 	\$60 Copay CYD/30% Coinsurance
Therapies <ul style="list-style-type: none"> • Physical, occupational and speech <ul style="list-style-type: none"> • Habilitative - Up to 120 visits per year • Rehabilitative - Up to 120 visits per year • Autism spectrum disorder - Up to 1,500 hours per year 	\$60 Copay \$60 Copay \$60 Copay
Pediatric Dental <ul style="list-style-type: none"> • Diagnostic and preventive services • Basic restorative procedures • Major restorative procedures • Orthodontia 	No Charge 30% Coinsurance 50% Coinsurance 50% Coinsurance
Pediatric Vision <ul style="list-style-type: none"> • Routine eye exam - One per year • Glasses - One pair of basic frames and lenses per year 	No Charge No Charge
ALL OTHER HOSPITAL AND OUTPATIENT SERVICES	\$1,000 Copay

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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.