SCHEDULE OF BENEFITS
PROMINENCE HEALTHFIRST
SMALL GROUP EMPLOYER PLAN

PROMINENCE POS FREEDOM 5 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 $750 single; $1,500 family** **PPO IN-NETWORK: Member pays $1,500 single; $3,000 family** **OUT-OF-NETWORK [(1)]: Member pays $6,000 single; $12,000 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 $8,000 single; $16,000 family PPO IN-NETWORK: Member pays $10,150 single; $20,300 family OUT-OF-NETWORK [1]: Member pays $30,000 single; $60,000 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.	

Your out-of-pocket expenses for HMO (Tier 1) accumulate toward both your HMO (Tier 1) and PPO in-network (Tier 2) out-of-pocket maximums. Your out-of-pocket expenses for PPO in-network (Tier 2) accumulate toward your PPO in-network (Tier 2) and HMO (Tier 1) calendar year out-of-pocket maximums. In no event will your out-of-pocket expenses for HMO (Tier 1) and PPO in-network (Tier 2) exceed your PPO In-Network (Tier 2) out-of-pocket maximums.

[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			
• Primary Care Provider (PCP) office & Telemedicine visits	**$0 Copay**	**$50 Copay**	**CYD/50% Coinsurance**
• Specialist office & Telemedicine visits	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
• Mental health outpatient office & Telemedicine visits	**$0 Copay**	**$50 Copay**	**CYD/50% Coinsurance**
• Alcohol and drug abuse treatment office visits	**$0 Copay**	**$50 Copay**	**CYD/50% Coinsurance**
Charges in addition to the office visit copay may include:			
• In-office surgical procedure	**$350 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• In-office injectable (excluding specialty drugs)	**CYD/ 10% coinsurance**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
There may be additional changes for other services in the provider's office.			
PriorityCare			
• wellPORTAL primary care (Available in southern Nevada only)	**$0 Copay**	**Not Applicable**	**Not Applicable**
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	**$50 Copay**	**$50 Copay**	**$50 Copay**
Laboratory / Pathology	**$0 Copay**	**$50 Copay**	**CYD/50% Coinsurance**

PHARMACY SERVICES Diabetic supplies are obtainable from a pharmacy (including needles, syringes, test strips, lancets and alcohol swabs available at retail or mail order). You won't pay more than $35 for a one-month supply of each covered insulin product.		
	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 • Mail Order (90-day supply)	 **$0 Copay** **$0 Copay**	 **Not Covered** **Not Covered**
Pharmacy Tier 2 - Preferred Brand • Retail • Mail Order (90-day supply)	 **$75 Copay** **$150 Copay**	 **Not Covered** **Not Covered**
Pharmacy Tier 3 - Non-preferred Brand • Retail • Mail Order (90-day supply)	 **$100 Copay** **$200 Copay**	 **Not Covered** **Not Covered**
Pharmacy Tier 4 - Specialty Drugs • Retail • Mail Order (90-day supply)	 **$400 Copay** **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	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
Ambulance Services - Medically necessary only			
• Air Ambulance		**$350 Copay**	
• Ground Ambulance		**$350 Copay**	
Durable Medical Equipment - Rental or purchase	**CYD/10% coinsurance**	**CYD/20% coinsurance**	**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.		**$350 Copay**	
Hearing Aids - Limit one set every three years	**CYD/10% coinsurance**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Home Health Care Limited to 30 visits per calendar year	**$0 Copay**	**$50 Copay**	**CYD/50% Coinsurance**
Hospice Care	**CYD/10% coinsurance**	**CYD/20% coinsurance**	**CYD/50% Coinsurance**
Hospital/Outpatient/Ambulatory Services Ambulatory and day-surgery series performed in a hospital or other			
• Outpatient surgery	**$350 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Inpatient surgery/admit	**CYD/10% coinsurance**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Observation - No additional copay if transferred from outpatient surgery	**CYD/10% coinsurance**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Inpatient skilled nursing - Up to 100 days per year	**CYD/10% coinsurance**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Acute rehabilitation - All Inpatient & Outpatient Rehabilitation & Habilitation Services area subject to a combined maximum benefit of 120 days/visits per Calendar Year.	**CYD/10% coinsurance**	**CYD/20% 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	**$750 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Infusion Therapy • Performed and billed by a physician's office or free-standing facility • Performed and billed by a hospital outpatient facility •	**CYD/10% coinsurance** **$350 Copay**	**CYD/20% Coinsurance** **CYD/20% 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** **CYD/10% coinsurance**	**$0 Copay** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**
Kidney Dialysis Services	**$350 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Mastectomy Reconstruction Services • Outpatient surgery • Inpatient surgery	**$350 Copay** **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 • 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** **$70 Copay**	**CYD/20% Coinsurance** **CYD/20% Coinsurance** **$100 Copay**	**CYD/50% Coinsurance** **CYD/50% Coinsurance** **CYD/50% Coinsurance**
Medical Nutrition Therapy Counseling - Up to 25 visits per year	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
Mental Health Services - Severe Mental Illness • Day treatment program/Outpatient • Inpatient	**$350 Copay** **CYD/10% coinsurance**	**CYD/20% Coinsurance** **CYD/20% Coinsurance**	**CYD/50% Coinsurance** **CYD/50% Coinsurance**
Alcohol and Drug Abuse Services • Inpatient withdrawal/rehabilitation • Outpatient rehabilitation/day treatment	**CYD/10% coinsurance** **$350 Copay**	**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 • 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			
• Specialist office visit	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
• Hospital outpatient therapy facility fee	**CYD/10% Coinsurance**	**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	**$25 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• CT Scan and MRI	**$350 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Imaging and Complex Diagnostic Testing	**$350 Copay**	**CYD/20% 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	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
Temporomandibular Joint Dysfunction			
• TMJ non-surgical outpatient office visit	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
• TMJ surgery - Inpatient hospital	**CYD/10% coinsurance**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
Therapies			
• Physical, occupational and speech All Inpatient & Outpatient Rehabilitation & Habilitation Services area subject to a combined maximum benefit of 120 days/visits per Calendar Year.			
◦ Habilitative	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
◦ Rehabilitative	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
• Autism spectrum disorder - Up to 1,500 hours per year	**$70 Copay**	**$100 Copay**	**CYD/50% Coinsurance**
Pediatric Dental Member will pay the lower of the provider's fee or the copay for in-network services.			
• Diagnostic and preventive services	**No Charge**	**No Charge**	**CYD/50% Coinsurance**
• Basic restorative procedures	**$350 Copay**	**CYD/20% Coinsurance**	**CYD/50% Coinsurance**
• Major restorative procedures	**CYD/10% coinsurance**	**CYD/40% Coinsurance**	**CYD/50% Coinsurance**
• Orthodontia	**CYD/10% coinsurance**	**CYD/40% 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**

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.