SCHEDULE OF BENEFITS
PROMINENCE HEALTHFIRST
LARGE GROUP EMPLOYER PLAN

PROMINENCE AHP HMO 17

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 $4,000 single; $8,000 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 $8,500 single; $17,000 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.	

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Provider Office Visits	
• wellPORTAL primary care (available in Southern Nevada only)	**$0 Copay**
• Preventive Services - *See Your EOC for a full list of Preventive Services*	**No Charge**
• Primary Care Provider (PCP) office & Telemedicine visits	**$25 Copay**
• Specialist office & Telemedicine visits	**$50 Copay**
• Mental health outpatient office & Telemedicine visits	**$25 Copay**
• Alcohol and drug abuse treatment office visits	**$25 Copay**
Charges in addition to the office visit copay may include:	
• In-office surgical procedure	**$500 Copay**
• In-office injectable (excluding specialty drugs)	**30% Coinsurance**
There may be additional changes for other services in the provider's	
Teladoc Virtual Visits at (800)TELADOC or teladoc.com	
• 27/7 Non-Urgent Care	**$0 Copay**
• Behavioral Health	**$0 Copay**
Urgent Care	**$50 Copay**
Laboratory / Pathology	
• Free Standing & Provider Office	**$0 Copay**
• Hospital Outpatient	**CYD/30% 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).	
Pharmacy Tier 0 - Preventive Includes certain vaccines, contraceptives, smoking cessation medications and more	**No Charge**
Pharmacy Tier 1 - Generic	
• Retail	**$25 Copay**
• Mail Order (90-day supply)	**$50 Copay**
Pharmacy Tier 2 - Preferred Brand	
• Retail	**$50 Copay**
• Mail Order (90-day supply)	**$100 Copay**
Pharmacy Tier 3 - Non-preferred Brand	
• Retail	**$75 Copay**
• Mail Order (90-day supply)	**$225 Copay**
Pharmacy Tier 4 - Specialty Drugs	
• Retail	**20% Coinsurance**
• Mail Order (90-day supply)	**Not Available**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Alternative Medicine Homeopathy, acupuncture and integrated medicine; $1,500 maximum	**$25 Copay**
Ambulance Services - Medically necessary only • Air Ambulance • Ground Ambulance	 **$500 Copay** **$500 Copay**
Durable Medical Equipment - Rental or purchase	**$30 Copay**
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/$2,000 Copay**
Hearing Aids - Limit one set every three years	**30% Coinsurance**
Home Health Care – Limited to 30 visits per calendar year	**$25 Copay**
Hospice Care	**$0 Copay**
Hospital/Outpatient/Ambulatory Services Ambulatory and day-surgery series performed in a hospital or other • Outpatient Ambulatory Surgery Center (ASC) surgery • Outpatient Hospital 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	 **$100 Copay** **$500 Copay** **CYD/$2,000 Copay** **$1,500 Copay** **CYD/$2,000 Copay** **CYD/$2,000 Copay**
Infusion Therapy • Performed and billed by a physician's office or free-standing facility • Performed and billed by a hospital outpatient facility	 **$25 Copay** **$500 Copay**
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** **$500 Copay**
Kidney Dialysis Services	**$25 Copay**
Mastectomy Reconstruction Services • Outpatient surgery • Inpatient surgery	 **$500 Copay** **CYD/$2,000 Copay**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Maternity	
• Physician: Prenatal care and delivery	**$200 Copay/delivery**
• Delivery room and well-baby hospital care	**CYD/$2,000 Copay**
• Ancillary maternity charges - Including but not limited to fetal non-stress tests and amniocentesis	**$25 Copay**
Medical Nutrition Therapy Counseling - Up to 25 visits per year	**$25 Copay**
Mental Health Services - Severe Mental Illness	
• Day treatment program/Outpatient	**$500 Copay**
• Inpatient	**CYD/$2,000 Copay**
Alcohol and Drug Abuse Services	
• Outpatient rehabilitation/day treatment	**$500 Copay**
• Inpatient withdrawal/rehabilitation	**CYD/$2,000 Copay**
Bariatric Surgery - Inpatient or outpatient; one procedure per lifetime	**CYD/$2,000 Copay**
Nutritional Supplements - Enteral formulas and parenteral nutrition; maximum 120 days supply	**$25 Copay**
Organ Transplants	**CYD/$2,000 Copay**
Ostomy Supplies	**$25 Copay**
Prosthetics and Orthotics	
• Prosthetics and Orthotics - Foot orthotics up to two pair per year	**30% Coinsurance**
• Dental/oral orthotic appliances - TMJ and/or sleep apnea up to one appliance per year	**30% Coinsurance**
• Post-cataract services - Up to one pair of basic frames and lenses per year	**$100 Copay**
Radiation Oncology Therapy	
• Specialist office visit	**$50 Copay**
• Hospital outpatient therapy facility fee	**$500 Copay**
Radiology and Diagnostic Services	
Some invasive diagnostic procedures are treated as outpatient hospital	
• Free-Standing & Provider Office	
◦ Routine X-ray and Routine Diagnostic Tests	**$25 Copay**
◦ CT Scan and MRI	**$500 Copay**
◦ Imaging and Complex Diagnostic Testing	**CYD/30% Coinsurance**
• Hospital Outpatient	
◦ Routine X-ray and Routine Diagnostic Tests	**CYD/30% Coinsurance**
◦ CT Scan and MRI	**CYD/30% Coinsurance**
◦ Imaging and Complex Diagnostic Testing	**CYD/30% Coinsurance**

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TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE
Spinal Manipulation - Up to 26 visits per year	**$50 Copay**
Temporomandibular Joint Dysfunction	
• TMJ non-surgical outpatient office visit	**$50 Copay**
• TMJ surgery - Inpatient hospital	**CYD/$2,000 Copay**
Therapies	
• Physical, occupational and speech	
• Habilitative - Up to 120 visits per year	**$50 Copay**
• Rehabilitative - Up to 120 visits per year	**$50 Copay**
• Autism spectrum disorder - Up to 1,500 hours per year	**$25 Copay**
Pediatric Dental	
• Diagnostic and preventive services	**No Charge**
• Basic restorative procedures	**20% Coinsurance**
• Major restorative procedures	**50% Coinsurance**
• Orthodontia	**50% Coinsurance**
Pediatric Vision	
• Routine eye exam - One per year	**No Charge**
• Glasses - One pair of basic frames and lenses per year	**No Charge**
ALL OTHER HOSPITAL AND OUTPATIENT SERVICES	**$500 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 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.