

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

**RSCC FREEDOM BEYOND 9**

**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](http://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**

<b>CALENDAR YEAR DEDUCTIBLE</b>	<b>IN-NETWORK: Member pays \$2,500 single; \$5,000 family        OUT-OF-NETWORK (1): Member pays \$7,500 single; \$15,000 family</b>
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.	
<b>COINSURANCE</b>	<b>IN-NETWORK: 30% coinsurance        OUT-OF-NETWORK: 50% coinsurance</b>
coinsurance is the percentage of the Allowed Amount that a Member must pay a Provider for Covered Services.	
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>	<b>IN-NETWORK: Member pays \$5,000 single; \$10,000 family        OUT-OF-NETWORK (1): Member pays \$10,000 single; \$20,000 family</b>
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"> <li>• Expenses for Covered Services in excess of the Allowed Amount;</li> <li>• Expenses for which no benefits are payable by the Plan; and</li> <li>• Expenses which become the Member’s responsibility for failure to comply with the Utilization Management Program or Prior Authorization requirements.</li> </ul>	

<sup>1</sup> 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.

<sup>1a</sup> When traveling or living outside the Prominence Service Area, you are eligible to receive Covered Services by a National Network Provider.

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LARGE GROUP EMPLOYER PLAN**

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**SCHEDULE OF BENEFITS**

TYPE OF SERVICE	YOUR OUT-OF-POCKET EXPENSE	
	IN-NETWORK <sup>1a</sup>	OUT-OF-NETWORK <sup>1</sup>
<b>Provider Office Visits</b> <ul style="list-style-type: none"> <li>wellPORTAL primary care</li> <li>Primary Care Provider (PCP) office &amp; Telemedicine visits</li> <li>Specialist office &amp; Telemedicine visits</li> <li>Mental health outpatient office &amp; Telemedicine visits</li> <li>Alcohol and drug abuse treatment office visits</li> </ul> <i>Charges in addition to the office visit copay may include:</i> <ul style="list-style-type: none"> <li>In-office surgical procedure</li> <li>In-office injectable (excluding specialty drugs)</li> </ul> <i>There may be additional charges for other services in the provider's</i>	\$0 copay \$30 copay \$60 copay \$30 copay \$30 copay  CYD/30% coinsurance 30% coinsurance	Not applicable CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance  CYD/50% coinsurance CYD/50% coinsurance
<b>Teladoc Virtual Visits at (800)TELADOC or <a href="http://teladoc.com">teladoc.com</a></b> <ul style="list-style-type: none"> <li>Primary Care</li> <li>Behavioral Health</li> </ul>	\$0 copay \$0 copay	Not applicable Not applicable
<b>Preventive Services</b> - See Your EOC for a full list of Preventive Services	<b>No Charge</b>	CYD/50% coinsurance
<b>Urgent Care</b>	\$50 copay	CYD/50% coinsurance
<b>Laboratory / Pathology</b> – Freestanding & Office	\$0 copay	CYD/50% coinsurance
<b>Laboratory / Pathology</b> – Hospital Outpatient	CYD/30% coinsurance	CYD/50% coinsurance
<b>PHARMACY SERVICES</b>		
Diabetic supplies are obtainable from a pharmacy (including needles, syringes, test strips, lancets and alcohol swabs available at retail or mail order).		
<b>Pharmacy Tier 0 - Preventive</b> Includes certain vaccines, contraceptives, smoking cessation medications and more	<b>No Charge</b>	<b>Not Covered</b>
<b>Pharmacy Tier 1 - Generic</b> <ul style="list-style-type: none"> <li>Retail</li> <li>Mail Order (90-day supply)</li> </ul>	\$25 copay \$50 copay	Not Covered Not Covered
<b>Pharmacy Tier 2 - Preferred Brand</b> <ul style="list-style-type: none"> <li>Retail</li> <li>Mail Order (90-day supply)</li> </ul>	\$50 copay \$100 copay	Not Covered Not Covered
<b>Pharmacy Tier 3 - Non-preferred Brand</b> <ul style="list-style-type: none"> <li>Retail</li> <li>Mail Order (90-day supply)</li> </ul>	\$75 copay \$225 copay	Not Covered Not Covered
<b>Pharmacy Tier 4 - Specialty Drugs</b> <ul style="list-style-type: none"> <li>Retail</li> <li>Mail Order (90-day supply)</li> </ul>	20% coinsurance Not Available	Not Covered Not Covered

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	IN-NETWORK <sup>1a</sup>	OUT-OF-NETWORK <sup>1</sup>
<b>Alternative Medicine</b> Homeopathy, acupuncture and integrated medicine; \$1,500 maximum	\$60 copay	CYD/50% coinsurance
<b>Ambulance Services - Medically necessary only</b> <ul style="list-style-type: none"> <li>Air Ambulance</li> <li>Ground Ambulance</li> </ul>	CYD/30% coinsurance CYD/30% coinsurance	
<b>Durable Medical Equipment</b> - Rental or purchase	CYD/30% coinsurance	CYD/50% coinsurance
<b>Emergency Care - Includes surgeon and physician charges</b> 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.	\$1,000 copay	
<b>Hearing Aids</b> - Limit one set every three years	CYD/30% coinsurance	CYD/50% coinsurance
<b>Home Health Care</b>	CYD/30% coinsurance	CYD/50% coinsurance
<b>Hospice Care</b> <ul style="list-style-type: none"> <li>Home care</li> <li>Hospital Inpatient</li> </ul>	No charge CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance
<b>Hospital/Outpatient/Ambulatory Services</b> Ambulatory and day-surgery series performed in a hospital or other facility. <ul style="list-style-type: none"> <li>Outpatient Ambulatory Surgery Center (ASC)</li> <li>Outpatient Hospital</li> <li>Inpatient Hospital</li> <li>Observation – No additional copay if transferred from outpatient surgery</li> <li>Inpatient skilled nursing – Up to 100 days per calendar year</li> <li>Acute rehabilitation – Up to 60 visits per condition per member per calendar year</li> </ul>	\$750 copay CYD/30% coinsurance CYD/30% coinsurance \$750 copay CYD/30% coinsurance CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance
<b>Infusion Therapy</b> <ul style="list-style-type: none"> <li>Performed and billed by a physician’s office or free-standing facility</li> <li>Performed and billed by a hospital outpatient facility</li> <li>In-network specialty infusions</li> </ul>	\$60 copay CYD/30% coinsurance 30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance Not applicable
<b>Oncology Infusion Therapy Drugs for select oncology treatments</b> <ul style="list-style-type: none"> <li>Performed and billed by a physician’s office or free-standing facility</li> <li>Performed and billed by a hospital outpatient facility</li> </ul>	\$0 copay CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance
<b>Kidney Dialysis Services</b>	CYD/30% coinsurance	CYD/50% coinsurance

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	IN-NETWORK <sup>1a</sup>	OUT-OF-NETWORK <sup>1</sup>
<b>Mastectomy Reconstruction Services</b> <ul style="list-style-type: none"> <li>Outpatient surgery</li> <li>Inpatient surgery</li> </ul>	CYD/30% coinsurance CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance
<b>Maternity</b> <ul style="list-style-type: none"> <li>Physician: Prenatal care and delivery</li> <li>Delivery room and well-baby hospital care</li> <li>Ancillary maternity charges - Including but not limited to fetal non-stress tests and amniocentesis</li> </ul>	\$200 copay/delivery CYD/30% coinsurance \$30 copay	CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance
<b>Medical Nutrition Therapy Counseling</b> - Up to 25 visits per year	\$30 copay	CYD/50% coinsurance
<b>Mental Health Services</b> - Severe Mental Illness & Substance Use Disorder <ul style="list-style-type: none"> <li>Day treatment program/Outpatient</li> <li>Inpatient</li> </ul>	CYD/30% coinsurance CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance
<b>Bariatric Surgery</b> - Inpatient or outpatient; one procedure per lifetime	CYD/30% coinsurance	CYD/50% coinsurance
<b>Nutritional Supplements</b> - Enteral formulas and parenteral nutrition; maximum 120 days supply	CYD/30% coinsurance	CYD/50% coinsurance
<b>Organ Transplants</b>	CYD/30% coinsurance	CYD/50% coinsurance
<b>Ostomy Supplies</b>	CYD/30% coinsurance	CYD/50% coinsurance
<b>Prosthetics and Orthotics</b> <ul style="list-style-type: none"> <li>Prosthetics and Orthotics - Foot orthotics up to one pair per year</li> <li>Dental/oral orthotic appliances - TMJ and/or sleep apnea up to one appliance per year</li> </ul>	CYD/30% coinsurance CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance
<b>Radiation Oncology Therapy</b> <ul style="list-style-type: none"> <li>Specialist office visit</li> <li>Hospital outpatient therapy facility fee</li> </ul>	\$60 copay \$750 copay	CYD/50% coinsurance CYD/50% coinsurance

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	IN-NETWORK <sup>1a</sup>	OUT-OF-NETWORK <sup>1</sup>
<b>Radiology and Diagnostic Services</b> Some invasive diagnostic procedures are treated as outpatient hospital visits. Freestanding & Office <ul style="list-style-type: none"> <li>Routine X-ray and Routine Diagnostic Tests</li> <li>CT Scan and MRI</li> <li>Imaging and Complex Diagnostic Testing</li> </ul> Hospital Outpatient <ul style="list-style-type: none"> <li>Routine X-ray and Routine Diagnostic Tests</li> <li>CT Scan and MRI</li> <li>Imaging and Complex Diagnostic Testing</li> </ul>	\$50 copay \$1,000 copay \$1,000 copay  CYD/30% coinsurance CYD/30% coinsurance CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance  CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance
<b>Spinal Manipulation</b> - Up to 26 visits per year	\$60 copay	CYD/50% coinsurance
<b>Temporomandibular Joint Dysfunction</b> <ul style="list-style-type: none"> <li>TMJ non-surgical outpatient office visit</li> <li>TMJ surgery - Inpatient hospital</li> </ul>	\$60 copay CYD/30% coinsurance	CYD/50% coinsurance CYD/50% coinsurance
<b>Therapies</b> <ul style="list-style-type: none"> <li>Physical, occupational and speech – Limited to 120 visits per calendar year for all three therapy types combined.</li> <li>Autism spectrum disorder - Up to 1,500 hours per year</li> </ul>	\$60 copay \$30 copay	CYD/50% coinsurance CYD/50% coinsurance
<b>Pediatric Dental – Coverage up to age 19</b> <ul style="list-style-type: none"> <li>Diagnostic and preventive services</li> <li>Basic restorative procedures</li> <li>Major restorative procedures</li> <li>Orthodontia</li> </ul>	No Charge CYD/20% coinsurance CYD/40% coinsurance CYD/40% coinsurance	20% coinsurance CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance
<b>Pediatric Vision – Coverage up to age 19</b> <ul style="list-style-type: none"> <li>Routine eye exam - One exam per year</li> <li>Low-vision exam – One exam per year</li> <li>Glasses - One pair of basic frames and lenses per year</li> </ul>	No Charge No Charge No Charge	CYD/50% coinsurance CYD/50% coinsurance CYD/50% coinsurance
<b>ALL OTHER HOSPITAL AND OUTPATIENT SERVICES</b>	CYD/30% coinsurance	CYD/50% coinsurance

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**Prescription Drug Coverage**

Visit [ProminenceHealthPlan.com](http://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](http://ProminenceMember.com) or call Prominence Care Advocate Team at (800)863-7515.

**Language Translation Services**

This information is available for free in other languages. Please call Prominence Care Advocate Team 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.