Prominence Health
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SUMMARY OF DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS

IN-NETWORK (HealthFirst)		OUT-OF-NETWORK	
Deductible (Ind/Fam)	**5,000 / $10,000**	Deductible (Ind/Fam)	**N/A**
Coinsurance	**30%**	Coinsurance	**N/A**
Out-of-Pocket Max (Ind/Fam)	**$10,000 / $20,000**	Out-of-Pocket Max (Ind/Fam)	**N/A**

All in-network and out-of-network maximums are combined. Deductibles, coinsurance and copays all accrue toward the OOPM. Use of the ER for non-emergency conditions cannot satisfy the OOPM. Copays do not count toward the deductible. OOPM does not include: expenses not covered by the Plan; expenses in excess of UCR; expenses resulting from failure to comply with Utilization Management requirements.

OFFICE & PRIMARY CARE	IN-NETWORK *HealthFirst*	*Out-of-Network*
ǂ Preventive Services *Annual wellness exams, screenings, immunizations per ACA schedule.*	★ **$0** ***Collaborative Care & wellPORTAL*** *STD: ǂ NO CHARGE*	*Not covered*
Primary Care Provider (PCP) *Office visit & telemedicine. Additional charges may apply for in-office procedures.*	★**$0** ***Collaborative Care & wellPORTAL*** *STD: $40 copay*	*Not covered*
Specialist Provider *Office visit & telemedicine. No referral required in-network.*	★**$0** ***Collaborative Care*** *STD: $60 copay*	*Not covered*
In-Office Injections *In-office injectable medications, excluding specialty drugs. Billed in addition to office visit.*	**30%** *coinsurance*	*Not covered*
In-Office Surgical Procedures *Surgical procedures performed in provider's office. Billed in addition to office visit.*	**$500** *copay*	*Not covered*
Mental Health & Substance Use *Outpatient office & telemedicine visit. General mental health and substance use disorder care.*	★**$0** ***Collaborative Care*** *STD: $40 copay*	*Not covered*
Pre/Post-Natal Visits *Prenatal care office visits, ancillary maternity charges including fetal non-stress test and amniocentesis.*	**$40** *copay* *Delivery: $200/delivery*	*Not covered*

TELADOC TELEMEDICINE	IN-NETWORK *HealthFirst*	*Out-of-Network*
24/7 Acute Care *Virtual urgent/acute care visits available 24 hours a day, 7 days a week.*	**$0** *copay*	*Not covered*
Mental Health *Virtual behavioral health and mental health visits.*	**$0** *copay*	*Not covered*

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PRESCRIPTION DRUG COVERAGE	IN-NETWORK RETAIL *30-day supply*	AMAZON PHARMACY MAIL ORDER *90-day supply*	*Out-of-Network*
ǂ Tier 0 – Essential Health Benefits *Vaccines, contraception, smoking cessation medications, and more.*	ǂ NO CHARGE	ǂ NO CHARGE	*Not covered*
Tier 1 – Generic Drugs *Formulary generic medications.*	**$25** *copay*	**$50** *copay*	*Not covered*
Tier 2 – Preferred Brand Drugs *Formulary preferred brand-name medications.*	**$50** copay	**$100** *copay*	*Not covered*
Tier 3 – Non-Preferred Brand Drugs *Formulary non-preferred brand-name medications.*	**$75** *copay*	**$225** *copay*	*Not covered*
Tier 4 – Specialty Drugs *High-cost specialty and biologic medications.*	**20%** *coinsurance*	*Not available*	*Not covered*
Diabetic supplies obtainable from a pharmacy (including needles, syringes, test strips, lancets and alcohol swabs) available at retail or mail order. You will not pay more than $35 for a one-month supply of each covered insulin product. Visit www.ProminenceHealthPlan.com for updated formulary and participating pharmacy information or call the Prominence Care Advocate team at 800-863-7515.			

LAB, DIAGNOSTICS & RADIOLOGY[2]	IN-NETWORK *HealthFirst*	*Out-of-Network*
Lab / Pathology -- Freestanding *Independent lab facility or physician office.*	**$0** *copay*	*Not covered*
Hospital Outpatient *Hospital-based outpatient lab facility.*	**$500** *copay*	
Routine X-Ray & Diagnostics *Freestanding facility or physician office. Routine diagnostic X-ray and diagnostic tests.*	★**$0** ***Collaborative Care***	*Not covered*
	STD: $25 copay	
CT / MRI / PET *Freestanding or physician office. Advanced cross-sectional imaging.*	★**$0** ***Collaborative Care***	*Not covered*
	STD: $500 copay	
Imaging & Complex Diagnostic Testing *Complex diagnostic imaging. Some invasive diagnostic procedures treated as outpatient hospital visits.*	★**$0** ***Collaborative Care***	*Not covered*
	STD: CYD/30% coinsurance	

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URGENT & EMERGENCY CARE	IN-NETWORK *HealthFirst*	*Out-of-Network*
Urgent Care *Walk-in urgent care centers. Per visit.*	**$50** *copay*	*Not covered*
Emergency Room *Copay waived when member is admitted as inpatient directly from the ER. Same copay applies for both tiers.*	**CYD/$2,000** *copay* *Waived if admitted*	***CYD/$2,000*** *copay*
Ambulance (Air & Ground) *Medically necessary emergency air and ground ambulance transport.*	***$1,000*** *copay per trip*	***$1,000*** *copay per trip*
Non-Emergency Ambulance *Medically necessary non-emergency ground transport.*	**$1,000** copay per trip	***$1,000*** *copay per trip*

HOSPITAL & FACILITY	IN-NETWORK *HealthFirst*	*Out-of-Network*
Ambulatory Surgery Center (ASC) *Day surgery at ambulatory surgical center.*	★**$0** ***Collaborative Care*** *STD: $100 copay*	*Not covered*
Outpatient Hospital Services *Outpatient hospital procedures and services other than surgery.*	★**$0** ***Collaborative Care*** *STD: $500 copay*	*Not covered*
Outpatient Hospital Surgery *Includes **Outpatient Mastectomy Reconstructive Surgery** and **TMJ Dysfunction surgical procedures**.*	★**$0** ***Collaborative Care*** *STD: $500 copay*	*Not covered*
Inpatient Hospital *Includes **Inpatient Maternity Delivery**; **Skilled Nursing** (100 days/yr), **Bariatric Surgery** (1/lifetime), **Organ Transplant**, **Inpatient Rehabilitation** (60 visits/condition/yr).*	**CYD/$2,000** *copay*	*Not covered*

THERAPY SERVICES	IN-NETWORK *HealthFirst*	*Out-of-Network*
Physical, Occupational & Speech Therapy *120 combined visits per calendar year for all three therapy types. Speech therapy for stuttering is not limited up to age 19.*	★**$0** ***Collaborative Care*** *STD: $60 copay*	*Not covered*
Spinal Manipulation *Includes all covered services related to spinal manipulation. Up to 26 visits per year.*	**$60** *copay*	*Not covered*
Autism Spectrum Disorder (ASD) *Applied behavior analysis and related therapies. Up to 1,500 hours per calendar year.*	★**$0** ***Collaborative Care*** *STD: $40 copay*	*Not covered*

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MENTAL HEALTH	IN-NETWORK *HealthFirst*	*Out-of-Network*
Mental Health & Substance Abuse — Office Visit *Outpatient office and telemedicine visits for mental health and substance use disorder.*	★**$0** ***Collaborative Care*** *STD: $40 copay*	*Not covered*
Teladoc Telemedicine — Mental Health *Virtual behavioral health and mental health visits via Teladoc platform.*	**$0** *copay*	*Not covered*
Outpatient Intensive MH & SUD Treatment *Day treatment programs for severe mental illness, alcohol and drug use disorder (intensive outpatient / partial hospitalization).*	★**$0** ***Collaborative Care*** *STD: $500 copay*	*Not covered*
Inpatient Severe MH & SUD Treatment *Inpatient care for severe mental illness, alcohol and drug abuse services.*	**CYD/$2,000** *copay*	*Not covered*

OTHER OFFICE VISITS	IN-NETWORK *HealthFirst*	*Out-of-Network*
Allergy Testing & Treatment *Allergy testing and immunotherapy injections.*	★**$0** ***Collaborative Care*** *STD: 30% coinsurance*	*Not covered*
Alternative Care *Homeopathy, acupuncture and integrated medicine. $1,500 maximum per calendar year combined.*	**$60** *copay*	*Not covered*
Medical Nutrition Therapy *Nutrition counseling visits with registered dietician. Up to 25 visits per calendar year.*	**$60** *copay*	*Not covered*
TMJ Dysfunction *Non-surgical outpatient office visits. TMJ surgery: see Outpatient Hospital Surgery.*	**$60** *copay*	*Not covered*

PEDIATRIC DENTAL & VISION *18-years and younger*	IN-NETWORK *HealthFirst*	*Out-of-Network*
ǂ **Diagnostic and preventive dental services**	ǂ NO CHARGE	*Not covered*
Basic restorative dental procedures	**20%** *coinsurance, deductible does not apply*	*Not covered*
Major restorative dental procedures	**50%** *coinsurance, deductible does not apply*	*Not covered*
Orthodontia	**50%** *coinsurance, deductible does not apply*	*Not covered*
ǂ **Routine eye exam** *One exam per year.*	ǂ NO CHARGE	*Not covered*
ǂ **Prescription eye glasses** *One pair of basic frames and lenses per year.*	ǂ NO CHARGE	*Not covered*

DURABLE MEDICAL EQUIPMENT & SUPPLIES	IN-NETWORK *HealthFirst*	*Out-of-Network*
General Durable Medical Equipment *Rental or purchase. Medically necessary; authorized per Medicare DME guidelines. Limited to one purchase/repair/replacement per item every 3 years.*	**$30** *copay*	*Not covered*
Diabetic Pump & Supplies *Insulin pumps and diabetic supplies from a DME supplier. Insulin: maximum $35 per one-month supply.*	**$30** *copay*	*Not covered*
CPAP / BiPAP Equipment & Supplies *Continuous and bilevel positive airway pressure equipment and related supplies.*	**$30** *copay*	*Not covered*
Prosthetics *Prosthetic devices and medically necessary replacements.*	**30%** *coinsurance*	*Not covered*
Orthotics *Foot orthotics up to one pair per year. Dental/oral orthotic appliances for TMJ and/or sleep apnea up to one per year.*	**30%** *coinsurance*	*Not covered*
Hearing Aids *Prescription hearing aid devices, batteries and repairs. One pair per year.*	**30%** *coinsurance*	*Not covered*
Nutritional Supplements *Medical-grade nutritional supplements for therapeutic needs. Enteral therapy and parenteral nutrition. Maximum 120-day supply.*	**$40** *copay*	*Not covered*
Ostomy Supplies *Medically necessary ostomy bags, appliances and related supplies.*	**$40** *copay*	*Not covered*

HOME HEALTH & HOSPICE	IN-NETWORK *HealthFirst*	*Out-of-Network*
Home Health Care *Skilled nursing, therapy and home health aide visits. Limited to 30 visits per calendar year.*	**$25** *copay*	*Not covered*
Residential Hospice Care *Home-based and residential hospice visits. Per visit copay.*	**$0** *copay*	*Not covered*
Inpatient Hospice Care *Hospital inpatient hospice admission when home care is not feasible.*	**CYD/$2,000** *copay*	*Not covered*
Hospice Care — Respite *Temporary respite care for caregiver relief. Up to 5 days per stay.*	**$40** *copay*	*Not covered*

ONCOLOGY, INFUSION & SPECIALTY	IN-NETWORK *HealthFirst*	*Out-of-Network*
Dialysis & Infusion Therapy — Freestanding *Kidney dialysis (renal/ESRD) and non-oncology infusion therapy at physician office or freestanding facility*.	★**$0** ***CC PARTNER*** *STD:* $60 *copay*	*Not covered*
Oncology Infusion — Freestanding *Select oncology treatments at physician office or freestanding facility.*	★**$0** ***CC PARTNER*** *STD:* $0 *copay*	*Not covered*
Oncology Infusion — Hospital Outpatient *Oncology infusion performed and billed by hospital outpatient facility.*	**$500** *copay*	*Not covered*
Radiation Oncology — Hospital Outpatient *Hospital outpatient therapy facility fee for radiation treatment.*	**$500** *copay*	*Not covered*

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★ COLLABORATIVE CARE PROGRAM & NETWORK OPTIONS	IN-NETWORK *HealthFirst*	*Out-of-Network*
Collaborative Care Program *Available in Northern Nevada. No referral required.*	★ **$0 copay**	*Not covered*
wellPORTAL Primary Care *Available in Southern Nevada. No referral required.*	**$0 copay**	*Not covered*
Teladoc 24/7 Acute Care *Virtual acute/urgent care visits are available 24/7 via Teladoc platform.*	**$0 copay**	*Not covered*
Teladoc Mental Health *Scheduled virtual mental health visits via Teladoc. Available to members 18-years-old and older.*	**$0 copay**	*Not covered*

★ The star symbol (★) identifies benefits available to members who engage in Collaborative Care or receive services from a designated wellPORTAL Provider or from Teladoc Health; cost-sharing of $0 applies only to covered services rendered by such providers and does not alter or waive any other applicable plan terms, prior authorization requirements, or covered-benefit limitations as defined in the Evidence of Coverage.

‡ This benefit is provided at no additional member cost-sharing pursuant to applicable state and/or federal mandate and applies equally across all network tiers regardless of provider designation.

CYD = Calendar Year Deductible must be satisfied before coinsurance percentage applies. Copays do not count toward the deductible.

UCR = Usual, Customary & Reasonable charge limits apply for out-of-network benefits; members may be responsible for all charges in excess of UCR.

OOPM = Out-of-Pocket Maximum. Copays, coinsurance and deductibles all accrue toward the OOPM. Use of the ER for non-emergency conditions cannot satisfy the OOPM.

[2] Some services listed may be billed as diagnostic procedures rather than preventive/screening, which could require member cost-sharing under "Lab, Diagnostics & Radiology" section.

Prominence Care Advocate Team: 800-863-7515 ◆TTY: 800-326-6868

www.prominencehealthplan.com