

**SUMMARY OF DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS**

TIER 1 (HealthFirst)		TIER 2 (UHN)		TIER 3—OUT-OF-NETWORK	
Deductible (Ind/Fam)	\$3,500 / \$7,000	Deductible (Ind/Fam)	\$4,000 / \$8,000	Deductible (Ind/Fam)	\$8,000 / \$16,000
Coinsurance	30%	Coinsurance	30%	Coinsurance	50%
Out-of-Pocket Max (Ind/Fam)	\$9,200 / \$18,400	Out-of-Pocket Max (Ind/Fam)	\$10,000 / \$20,000	Out-of-Pocket Max (Ind/Fam)	\$20,000 / \$40,000

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	TIER 1 HealthFirst	TIER 2 <sup>1</sup> UHN	TIER 3 Out-of-Network
<b>≠ Preventive Services</b> <i>Annual wellness exams, screenings, immunizations per ACA schedule.</i>	<b>★\$0</b> <i>Collaborative Care &amp; wellPORTAL</i> STD: ≠ NO CHARGE	≠ No Charge	CYD/50% coinsurance
<b>Primary Care Provider (PCP)</b> <i>Office visit &amp; telemedicine. Additional charges may apply for in-office procedures.</i>	<b>★\$0</b> <i>Collaborative Care &amp; wellPORTAL</i> STD: \$40 copay	\$60 copay	CYD/50% coinsurance
<b>Specialist Provider</b> <i>Office visit &amp; telemedicine. No referral required in-network.</i>	<b>★\$0</b> <i>Collaborative Care</i> STD: \$60 copay	\$75 copay	CYD/50% coinsurance
<b>In-Office Injections</b> <i>In-office injectable medications, excluding specialty drugs. Billed in addition to office visit.</i>	\$60 copay	\$75 copay	CYD/50% coinsurance
<b>In-Office Surgical Procedures</b> <i>Surgical procedures performed in provider's office. Billed in addition to office visit.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>Mental Health &amp; Substance Use</b> <i>Outpatient office &amp; telemedicine visit. General mental health and substance use disorder care.</i>	<b>★\$0</b> <i>Collaborative Care</i> STD: \$40 copay	\$60 copay	CYD/50% coinsurance
<b>Pre/Post-Natal Visits</b> <i>Prenatal care office visits, ancillary maternity charges including fetal non-stress test and amniocentesis.</i>	\$40 copay Delivery: \$250 copay/delivery	\$60 copay Delivery: CYD/30% coinsurance/delivery	CYD/50% coinsurance

TELADOC TELEMEDICINE	TIER 1 HealthFirst	TIER 2 <sup>1</sup> UHN	TIER 3 Out-of-Network
<b>24/7 Acute Care</b> <i>Virtual urgent/acute care visits available 24 hours a day, 7 days a week.</i>	\$0 copay	Covered under Tier 1	Not applicable
<b>Mental Health</b> <i>Virtual behavioral health and mental health visits via Teladoc.</i>	\$0 copay	Covered under Tier 1	Not applicable

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<b>PRESCRIPTION DRUG COVERAGE</b>	<b>IN-NETWORK RETAIL</b> <i>30-day supply</i>	<b>AMAZON PHARMACY MAIL ORDER</b> <i>90-day supply</i>	<b>Out-of-Network</b>
<b>‡ Tier 0 – Essential Health Benefits</b> <i>Vaccines, contraception, smoking cessation medications, and more.</i>	‡ NO CHARGE	‡ NO CHARGE	<i>Not covered</i>
<b>Tier 1 – Generic Drugs</b> <i>Formulary generic medications.</i>	\$25 copay	\$50 copay	<i>Not covered</i>
<b>Tier 2 – Preferred Brand Drugs</b> <i>Formulary preferred brand-name medications.</i>	\$50 copay	\$100 copay	<i>Not covered</i>
<b>Tier 3 – Non-Preferred Brand Drugs</b> <i>Formulary non-preferred brand-name medications.</i>	\$75 copay	\$225 copay	<i>Not covered</i>
<b>Tier 4 – Specialty Drugs</b> <i>High-cost specialty and biologic medications.</i>	20% coinsurance	<i>Not available</i>	<i>Not covered</i>
<i>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 <a href="http://www.ProminenceHealthPlan.com">www.ProminenceHealthPlan.com</a> for updated formulary and participating pharmacy information or call the Prominence Care Advocate team at 800-863-7515.</i>			

<b>LAB, DIAGNOSTICS &amp; RADIOLOGY<sup>2</sup></b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Lab / Pathology -- Freestanding</b> <i>Independent lab facility or physician office.</i>	\$0 copay	\$0 copay	CYD/50% coinsurance
<b>Hospital Outpatient</b> <i>Hospital-based outpatient lab facility.</i>	\$500 copay	\$CYD/30% coinsurance	
<b>Routine X-Ray &amp; Diagnostics</b> <i>Freestanding facility or physician office. Routine diagnostic X-ray and diagnostic tests.</i>	★\$0 <i>Collaborative Care</i> STD: \$25 copay	\$50 copay	CYD/50% coinsurance
<b>CT / MRI / PET</b> <i>Advanced cross-sectional imaging at freestanding or physician office facility.</i>	★\$0 <i>Collaborative Care</i> STD: \$500 copay	CYD/30% coinsurance	CYD/50% coinsurance
<b>Imaging &amp; Complex Diagnostic Testing</b> <i>Complex diagnostic imaging. Some invasive diagnostic procedures treated as outpatient hospital visits.</i>	★\$0 <i>Collaborative Care</i> STD: CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance

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<b>URGENT &amp; EMERGENCY CARE</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Urgent Care</b> <i>Walk-in urgent care centers. Per visit.</i>	<b>\$50 copay</b>	<b>\$100 copay</b>	<b>CYD/50% coinsurance</b>
<b>Emergency Room</b> <i>Copay waived when member is admitted as inpatient directly from the ER. Same copay applies all tiers.</i>	<b>CYD/30% coinsurance</b> <i>Waived if admitted</i>	<b>CYD/30% coinsurance</b> <i>Waived if admitted</i>	<b>CYD/30% coinsurance</b> <i>Waived if admitted</i>
<b>Ambulance (Air &amp; Ground)</b> <i>Medically necessary emergency air and ground ambulance transport.</i>	<b>\$500 copay per trip</b>	<b>\$500 copay per trip</b>	<b>\$500 copay per trip</b>
<b>Non-Emergency Ambulance</b> <i>Medically necessary non-emergency ground transport.</i>	<b>\$500 copay per trip</b>	<b>\$500 copay per trip</b>	<b>\$500 copay per trip</b>

<b>HOSPITAL &amp; FACILITY</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Ambulatory Surgery Center (ASC)</b> <i>Day surgery at ambulatory surgical center.</i>	<b>★ \$0</b> <i>Collaborative Care</i> <i>STD: \$100 copay</i>	<b>CYD/30% coinsurance</b>	<b>CYD/50% coinsurance</b>
<b>Outpatient Hospital Services</b> <i>Outpatient hospital procedures and services other than surgery.</i>	<b>★ \$0</b> <i>Collaborative Care</i> <i>STD: \$500 copay</i>	<b>CYD/30% coinsurance</b>	<b>CYD/50% coinsurance</b>
<b>Outpatient Hospital Surgery</b> <i>Includes Outpatient Mastectomy Reconstructive Surgery and TMJ Dysfunction surgical procedures.</i>	<b>\$500 copay</b>	<b>CYD/30% coinsurance</b>	<b>CYD/50% coinsurance</b>
<b>Inpatient Hospital</b> <i>Includes: Inpatient Maternity Delivery; Skilled Nursing (100 days/yr), Bariatric Surgery (1/lifetime), Organ Transplant, Inpatient Rehabilitation (60 visits/condition/yr).</i>	<b>CYD/\$2,000 copay</b>	<b>CYD/30% coinsurance</b>	<b>CYD/50% coinsurance</b>

<b>THERAPY SERVICES</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Physical, Occupational &amp; Speech Therapy</b> <i>120 combined visits per calendar year for all three therapy types. Speech therapy for stuttering not limited up to age 19.</i>	<b>★ \$0</b> <i>Collaborative Care</i> <i>STD: \$60 copay</i>	<b>\$75 copay</b>	<b>CYD/50% coinsurance</b>
<b>Spinal Manipulation</b> <i>Includes all covered services related to spinal manipulation. Up to 26 visits per year.</i>	<b>\$60 copay</b>	<b>\$75 copay</b>	<b>CYD/50% coinsurance</b>
<b>Autism Spectrum Disorder (ASD)</b> <i>Applied behavior analysis and related therapies. Up to 1,500 hours per calendar year.</i>	<b>★ \$0</b> <i>Collaborative Care</i> <i>STD: \$40 copay</i>	<b>\$60 copay</b>	<b>CYD/50% coinsurance</b>

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<b>MENTAL HEALTH</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Mental Health &amp; Substance Abuse — Office Visit</b> <i>Outpatient office and telemedicine visits for mental health and substance use disorder.</i>	<b>★\$0</b> <i>Collaborative Care</i>	<b>\$60 copay</b>	<b>CYD/50% coinsurance</b>
	<i>STD: \$40 copay</i>		
<b>Teladoc Telemedicine — Mental Health</b> <i>Virtual behavioral health and mental health visits via Teladoc platform.</i>	<b>\$0 copay</b>	<i>Covered under Tier 1</i>	<i>Not applicable</i>
<b>Outpatient Intensive MH &amp; SUD Treatment</b> <i>Day treatment programs for severe mental illness, alcohol and drug use disorder (intensive outpatient / partial hospitalization).</i>	<b>★\$0</b> <i>Collaborative Care</i>	<b>CYD/30% coinsurance</b>	<b>CYD/50% coinsurance</b>
	<i>STD: \$500 copay</i>		
<b>Inpatient Severe MH &amp; SUD Treatment</b> <i>Inpatient care for severe mental illness, alcohol and drug abuse services.</i>	<b>CYD/\$2,000 copay</b>	<b>CYD/30% coinsurance</b>	<b>CYD/50% coinsurance</b>

<b>OTHER OFFICE VISITS</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Allergy Testing &amp; Treatment</b> <i>Allergy testing and immunotherapy injections.</i>	<b>★\$0</b> <i>Collaborative Care</i>	<b>30% coinsurance</b>	<b>CYD/50% coinsurance</b>
	<i>STD: 30% coinsurance</i>		
<b>Alternative Care</b> <i>Homeopathy, acupuncture and integrated medicine. \$1,500 maximum per calendar year combined.</i>	<b>\$60 copay</b>	<b>\$75 copay</b>	<b>CYD/50% coinsurance</b>
<b>Medical Nutrition Therapy with a Registered Dietician</b> <i>Nutrition counseling visits with registered dietician. Up to 25 visits per calendar year.</i>	<b>\$60 copay</b>	<b>\$75 copay</b>	<b>CYD/50% coinsurance</b>
<b>TMJ Dysfunction</b> <i>Non-surgical outpatient office visits. TMJ surgery: see Outpatient Hospital Surgery.</i>	<b>\$60 copay</b>	<b>\$75 copay</b>	<b>CYD/50% coinsurance</b>

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<b>PEDIATRIC DENTAL &amp; VISION</b> <i>18-years &amp; under</i>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>‡ Diagnostic and preventive dental services</b>	‡ NO CHARGE	NO CHARGE	50% after deductible
<b>Basic restorative dental procedures</b>	20% after deductible	20% after deductible	50% after deductible
<b>Major restorative dental procedures</b>	40% after deductible	40% after deductible	50% after deductible
<b>Orthodontia</b>	40% after deductible	40% after deductible	50% after deductible
<b>‡ Routine eye exam</b> <i>One exam per year.</i>	‡ NO CHARGE	50% after deductible	50% after deductible
<b>‡ Prescription eye glasses</b> <i>One pair of basic frames and lenses per year.</i>	‡ NO CHARGE	50% after deductible	50% after deductible
<b>DURABLE MEDICAL EQUIPMENT &amp; SUPPLIES</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>General Durable Medical Equipment</b> <i>Rental or purchase. Medically necessary; authorized per Medicare DME guidelines. Limited to one purchase/repair/replacement per item every 3 years.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>Diabetic Pump &amp; Supplies</b> <i>Insulin pumps and diabetic supplies from a DME supplier. Insulin: maximum \$35 per one-month supply.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>CPAP / BiPAP Equipment &amp; Supplies</b> <i>Continuous and bilevel positive airway pressure equipment and related supplies.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>Prosthetics</b> <i>Prosthetic devices and medically necessary replacements.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>Orthotics</b> <i>Foot orthotics up to one pair per year. Dental/oral orthotic appliances for TMJ and/or sleep apnea up to one per year.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>Hearing Aids</b> <i>Prescription hearing aid devices, batteries and repairs. One pair per year.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance
<b>Nutritional Supplements</b> <i>Medical-grade nutritional supplements for therapeutic needs. Enteral therapy and parenteral nutrition. Maximum 120-day supply.</i>	20% coinsurance	20% coinsurance	CYD/50% coinsurance
<b>Ostomy Supplies</b> <i>Medically necessary ostomy bags, appliances and related supplies.</i>	CYD/30% coinsurance	CYD/30% coinsurance	CYD/50% coinsurance

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<b>HOME HEALTH &amp; HOSPICE</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Home Health Care</b> <i>Skilled nursing, therapy and home health aide visits. Limited to 30 visits per calendar year.</i>	\$40 copay	\$60 copay	CYD/50% coinsurance
<b>Residential Hospice Care</b> <i>Home-based and residential hospice visits. Per visit copay.</i>	\$0 copay	\$0 copay	CYD/50% coinsurance
<b>Inpatient Hospice Care</b> <i>Hospital inpatient hospice admission when home care is not feasible.</i>	CYD/\$2,000 copay	CYD/30% coinsurance	CYD/50% coinsurance
<b>Hospice Care — Respite</b> <i>Temporary respite care for caregiver relief. Up to 5 days per stay.</i>	\$40 copay	\$60 copay	Not applicable

<b>ONCOLOGY, INFUSION &amp; SPECIALTY</b>	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<b>TIER 3</b> <i>Out-of-Network</i>
<b>Dialysis &amp; Infusion Therapy — Freestanding</b> <i>Kidney dialysis (renal/ESRD) and non-oncology infusion therapy at physician office or freestanding facility.</i>	★ \$0 <i>Collaborative Care</i>	\$75 copay	CYD/50% coinsurance
	<i>STD: \$60 copay</i>		
<b>Oncology Infusion — Freestanding</b> <i>Select oncology treatments at physician office or freestanding facility.</i>	★ \$0 <i>Collaborative Care</i>	CYD/30% coinsurance	CYD/50% coinsurance
	<i>STD: \$0 copay</i>		
<b>Oncology Infusion — Hospital Outpatient</b> <i>Oncology infusion performed and billed by hospital outpatient facility.</i>	\$500 copay	CYD/30% coinsurance	CYD/50% coinsurance
<b>Radiation Oncology — Hospital Outpatient</b> <i>Hospital outpatient therapy facility fee for radiation treatment.</i>	\$500 copay	CYD/30% coinsurance	CYD/50% coinsurance

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<b>★ COLLABORATIVE CARE PROGRAM &amp; NETWORK OPTIONS</b>			
	<b>TIER 1</b> <i>HealthFirst</i>	<b>TIER 2<sup>1</sup></b> <i>UHN</i>	<i>Out-of-Network</i>
<b>Collaborative Care Partners</b> <i>Available in Northern Nevada. No referral required.</i>	<b>★\$0</b>	N/A	<i>Not applicable</i>
<b>wellPORTAL Primary Care</b> <i>Available in Southern Nevada. No referral required.</i>	<b>\$0</b>	N/A	<i>Not applicable</i>
<b>Teladoc T--24/7 Acute Care</b> <i>Virtual acute/urgent care visits available 24/7 via Teladoc platform.</i>	<b>\$0</b>	<b>\$0</b> <i>Covered under Tier 1</i>	<i>Not applicable</i>
<b>Teladoc --Mental Health</b> <i>Scheduled virtual mental health visits via Teladoc. Tier 2 members also covered at \$0. For members 18-years old and older.</i>	<b>\$0</b>	<b>\$0</b> <i>Covered under Tier 1</i>	<i>Not applicable</i>

★ 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 Tier 3 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.

<sup>1</sup> When travelling or living outside the Prominence UHN service areas, members are eligible to receive medical care by a National Network Provider under Tier 2 (In-Network) benefits.

<sup>2</sup> 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

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