

AHP HMO 9

SUMMARY OF DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS

IN-NETWORK (HealthFirst)		OUT-OF-NETWORK	
Deductible (Ind/Fam)	2,500 / \$5,000	Deductible (Ind/Fam)	N/A
Coinsurance	20%	Coinsurance	N/A
Out-of-Pocket Max (Ind/Fam)	\$8,500 / \$17,000	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
‡ Preventive Services <i>Annual wellness exams, screenings, immunizations per ACA schedule.</i>	★ \$0 Collaborative Care & wellPORTAL STD: ‡ NO CHARGE	Not covered
Primary Care Provider (PCP) <i>Office visit & telemedicine. Additional charges may apply for in-office procedures.</i>	★ \$0 Collaborative Care & wellPORTAL STD: \$25 copay	Not covered
Specialist Provider <i>Office visit & telemedicine. No referral required in-network.</i>	★ \$0 Collaborative Care STD: \$50 copay	Not covered
In-Office Injections <i>In-office injectable medications, excluding specialty drugs. Billed in addition to office visit.</i>	20% coinsurance	Not covered
In-Office Surgical Procedures <i>Surgical procedures performed in provider's office. Billed in addition to office visit.</i>	\$250 copay	Not covered
Mental Health & Substance Use <i>Outpatient office & telemedicine visit. General mental health and substance use disorder care.</i>	★ \$0 Collaborative Care STD: \$25 copay	Not covered
Pre/Post-Natal Visits <i>Prenatal care office visits, ancillary maternity charges including fetal non-stress test and amniocentesis.</i>	\$25 copay Delivery: \$200/delivery	Not covered

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

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PRESCRIPTION DRUG COVERAGE	IN-NETWORK RETAIL <i>30-day supply</i>	AMAZON PHARMACY MAIL ORDER <i>90-day supply</i>	<i>Out-of-Network</i>
‡ Tier 0 – Essential Health Benefits <i>Vaccines, contraception, smoking cessation medications, and more.</i>	‡ NO CHARGE	‡ NO CHARGE	<i>Not covered</i>
Tier 1 – Generic Drugs <i>Formulary generic medications.</i>	\$15 copay	\$30 copay	<i>Not covered</i>
Tier 2 – Preferred Brand Drugs <i>Formulary preferred brand-name medications.</i>	\$40 copay	\$80 copay	<i>Not covered</i>
Tier 3 – Non-Preferred Brand Drugs <i>Formulary non-preferred brand-name medications.</i>	\$60 copay	\$180 copay	<i>Not covered</i>
Tier 4 – Specialty Drugs <i>High-cost specialty and biologic medications.</i>	20% coinsurance	Not available	<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 www.ProminenceHealthPlan.com for updated formulary and participating pharmacy information or call the Prominence Care Advocate team at 800-863-7515.</i>			

LAB, DIAGNOSTICS & RADIOLOGY²	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Lab / Pathology --		
Freestanding <i>Independent lab facility or physician office.</i>	\$0 copay	<i>Not covered</i>
Hospital Outpatient <i>Hospital-based outpatient lab facility.</i>	\$250 copay	
Routine X-Ray & Diagnostics <i>Freestanding facility or physician office. Routine diagnostic X-ray and diagnostic tests.</i>	★\$0 <i>Collaborative Care</i> STD: \$25 copay	<i>Not covered</i>
CT / MRI / PET <i>Freestanding or physician office. Advanced cross-sectional imaging.</i>	★\$0 <i>Collaborative Care</i> STD: \$250 copay	<i>Not covered</i>
Imaging & Complex Diagnostic Testing <i>Complex diagnostic imaging. Some invasive diagnostic procedures treated as outpatient hospital visits.</i>	★\$0 <i>Collaborative Care</i> STD: CYD/20% coinsurance	<i>Not covered</i>

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URGENT & EMERGENCY CARE	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Urgent Care <i>Walk-in urgent care centers. Per visit.</i>	\$50 copay	<i>Not covered</i>
Emergency Room <i>Copay waived when member is admitted as inpatient directly from the ER. Same copay applies for both tiers.</i>	CYD/20% coinsurance <i>Waived if admitted</i>	CYD/20% coinsurance
Ambulance (Air & Ground) <i>Medically necessary emergency air and ground ambulance transport.</i>	\$250 copay per trip	\$250 copay per trip
Non-Emergency Ambulance <i>Medically necessary non-emergency ground transport.</i>	\$250 copay per trip	\$250 copay per trip

HOSPITAL & FACILITY	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Ambulatory Surgery Center (ASC) <i>Day surgery at ambulatory surgical center.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$0 copay</i>	
Outpatient Hospital Services <i>Outpatient hospital procedures and services other than surgery.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$250 copay</i>	
Outpatient Hospital Surgery <i>Includes Outpatient Mastectomy Reconstructive Surgery and TMJ Dysfunction surgical procedures.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$250 copay</i>	
Inpatient Hospital <i>Includes Inpatient Maternity Delivery; Skilled Nursing (100 days/yr), Bariatric Surgery (1/lifetime), Organ Transplant, Inpatient Rehabilitation (60 visits/condition/yr).</i>	CYD/\$1,000 copay	<i>Not covered</i>

THERAPY SERVICES	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Physical, Occupational & Speech Therapy <i>120 combined visits per calendar year for all three therapy types. Speech therapy for stuttering is not limited up to age 19.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$50 copay</i>	
Spinal Manipulation <i>Includes all covered services related to spinal manipulation. Up to 26 visits per year.</i>	\$50 copay	<i>Not covered</i>
Autism Spectrum Disorder (ASD) <i>Applied behavior analysis and related therapies. Up to 1,500 hours per calendar year.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$25 copay</i>	

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MENTAL HEALTH	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Mental Health & Substance Abuse — Office Visit <i>Outpatient office and telemedicine visits for mental health and substance use disorder.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$25 copay</i>	
Teladoc Telemedicine — Mental Health <i>Virtual behavioral health and mental health visits via Teladoc platform.</i>	\$0 copay	<i>Not covered</i>
Outpatient Intensive MH & SUD Treatment <i>Day treatment programs for severe mental illness, alcohol and drug use disorder (intensive outpatient / partial hospitalization).</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: \$250 copay</i>	
Inpatient Severe MH & SUD Treatment <i>Inpatient care for severe mental illness, alcohol and drug abuse services.</i>	CYD/\$1,000 copay	<i>Not covered</i>

OTHER OFFICE VISITS	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Allergy Testing & Treatment <i>Allergy testing and immunotherapy injections.</i>	★\$0 <i>Collaborative Care</i>	<i>Not covered</i>
	<i>STD: 20% coinsurance</i>	
Alternative Care <i>Homeopathy, acupuncture and integrated medicine. \$1,500 maximum per calendar year combined.</i>	\$25 copay	<i>Not covered</i>
Medical Nutrition Therapy <i>Nutrition counseling visits with registered dietician. Up to 25 visits per calendar year.</i>	\$25 copay	<i>Not covered</i>
TMJ Dysfunction <i>Non-surgical outpatient office visits. TMJ surgery: see Outpatient Hospital Surgery.</i>	\$50 copay	<i>Not covered</i>

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

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DURABLE MEDICAL EQUIPMENT & SUPPLIES	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
General Durable Medical Equipment <i>Rental or purchase. Medically necessary; authorized per Medicare DME guidelines. Limited to one purchase/repair/replacement per item every 3 years.</i>	\$25 copay	<i>Not covered</i>
Diabetic Pump & Supplies <i>Insulin pumps and diabetic supplies from a DME supplier. Insulin: maximum \$35 per one-month supply.</i>	\$25 copay	<i>Not covered</i>
CPAP / BiPAP Equipment & Supplies <i>Continuous and bilevel positive airway pressure equipment and related supplies.</i>	\$25 copay	<i>Not covered</i>
Prosthetics <i>Prosthetic devices and medically necessary replacements.</i>	20% coinsurance	<i>Not covered</i>
Orthotics <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>	20% coinsurance	<i>Not covered</i>
Hearing Aids <i>Prescription hearing aid devices, batteries and repairs. One pair per year.</i>	20% coinsurance	<i>Not covered</i>
Nutritional Supplements <i>Medical-grade nutritional supplements for therapeutic needs. Enteral therapy and parenteral nutrition. Maximum 120-day supply.</i>	\$25 copay	<i>Not covered</i>
Ostomy Supplies <i>Medically necessary ostomy bags, appliances and related supplies.</i>	\$25 copay	<i>Not covered</i>

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HOME HEALTH & HOSPICE	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Home Health Care <i>Skilled nursing, therapy and home health aide visits. Limited to 30 visits per calendar year.</i>	\$25 copay	<i>Not covered</i>
Residential Hospice Care <i>Home-based and residential hospice visits. Per visit copay.</i>	\$0 copay	<i>Not covered</i>
Inpatient Hospice Care <i>Hospital inpatient hospice admission when home care is not feasible.</i>	CYD/\$1,000 copay	<i>Not covered</i>
Hospice Care — Respite <i>Temporary respite care for caregiver relief. Up to 5 days per stay.</i>	\$25 copay	<i>Not covered</i>

ONCOLOGY, INFUSION & SPECIALTY	IN-NETWORK <i>HealthFirst</i>	<i>Out-of-Network</i>
Dialysis & Infusion Therapy — Freestanding <i>Kidney dialysis (renal/ESRD) and non-oncology infusion therapy at physician office or freestanding facility.</i>	★\$0 CC PARTNER	<i>Not covered</i>
	<i>STD: \$50 copay</i>	
Oncology Infusion — Freestanding <i>Select oncology treatments at physician office or freestanding facility.</i>	★\$0 CC PARTNER	<i>Not covered</i>
	<i>STD: \$0 copay</i>	
Oncology Infusion — Hospital Outpatient <i>Oncology infusion performed and billed by hospital outpatient facility.</i>	\$250 copay	<i>Not covered</i>
Radiation Oncology — Hospital Outpatient <i>Hospital outpatient therapy facility fee for radiation treatment.</i>	\$250 copay	<i>Not covered</i>

★ COLLABORATIVE CARE PROGRAM & NETWORK OPTIONS

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