Prominence Health
Schedule of Benefits
Association Health Plan

RSCC CONCIERGE

SUMMARY OF DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS

IN-NETWORK (UHN)		OUT-OF-NETWORK	
Deductible (Ind/Fam)	**$0 / $0**	Deductible (Ind/Fam)	**$0 / $0**
Coinsurance	**0%**	Coinsurance	**50%**
Out-of-Pocket Max (Ind/Fam)	**$5,000 / $10,000**	Out-of-Pocket Max (Ind/Fam)	**$10,000 / $20,000**

Deductibles, coinsurance, and copayments all accrue toward the Out-of-Pocket Maximum (OOPM). Copayments do not count toward the Calendar Year Deductible (CYD). Use of the Emergency Room (ER) for non-emergency conditions does not count towards the OOPM. The OOPM does not include expenses not covered by the plan, expenses more than the Usual, Customary & Reasonable (UCR) amount, or expenses resulting from a failure to comply with Utilization Management requirements.

OFFICE-BASED PHYSICIAN SERVICES	IN-NETWORK[1] *UHN*	*Out-of-Network*
Preventive Services *Annual wellness exams, screenings, immunizations per ACA schedule.*	***$0** copay*	*50% coinsurance after deductible*
Teledoc Telemedicine **24/7 Acute Care:** *Virtual urgent/acute care visits available 24 hours a day, 7 days a week.* **Mental Health:** *Virtual behavioral health and mental health visits.*	**$0** *copay*	*Not available*
Primary Care Provider (PCP) *Office visit and telemedicine. Additional charges may apply for in-office procedures.*	***$0** copay*	*50% coinsurance after deductible*
Specialist Provider *Office visit and telemedicine for Allergy, Dermatology, Endocrinology, Infectious Disease, OB/GYN, Pain, Pulmonary, Sleep, and all specialty visits.* ***Alternative Care:** Homeopathy, acupuncture and integrated medicine. $1,500 maximum per calendar year combined.* ***Medical Nutrition Therapy:** Nutrition counseling visits with registered dietitian. Up to 25 visits per calendar year.* ***TMJ Dysfunction:** Non-surgical office visits.*	**$60** *copay*	*50% coinsurance after deductible*
In-Office Injections & Infusions *In-office injectable medications, excluding specialty drugs. Billed in addition to office visit. Prior Authorization required.*	**$75** *copay*	*50% coinsurance after deductible*
In-Office Surgical Procedures *Surgical procedures performed in provider's office billed in addition to office visit. No facility charge.*	**$500** *copay*	*50% coinsurance after deductible*

LAB, DIAGNOSTICS & RADIOLOGY[2]	IN-NETWORK[1] *UHN*	*Out-of-Network*
Lab / Pathology[2]		
In-Office (Provider's office)	**$0** *copay*	*50% coinsurance after deductible*
Freestanding/Independent (Outpatient independent lab facility)	**$0** *copay*	*50% coinsurance after deductible*
Hospital Outpatient (Hospital-based outpatient lab facility)	**$50** *copay*	*50% coinsurance after deductible*
Routine X-Ray & Diagnostic Tests[2]		
In-Office (Physician's office)	**$100** *copay*	*50% coinsurance after deductible*
Freestanding/Independent (Outpatient independent facility)	**$100** *copay*	*50% coinsurance after deductible*
Hospital Outpatient (Hospital-based outpatient facility)	**$100** *copay*	*50% coinsurance after deductible*
Imaging & Complex Diagnostic Testing *(MRI, CT, PET, nuclear)* *Some invasive diagnostic procedures are treated as outpatient hospital visits.*		
In-Office	**$100** *copay*	*50% coinsurance after deductible*
Freestanding/Independent *Limited to lowest cost provider within 50 miles.*	**$100** *copay*	*50% coinsurance after deductible*
Hospital Outpatient *Limited to lowest cost provider within 50 miles.*	**$1,000** *copay*	*50% coinsurance after deductible*

EMERGENCY & URGENT CARE	IN-NETWORK[1] *UHN*	*Out-of-Network*
Urgent Care		
Walk-In Clinic (Retail urgent care clinic--not hospital based)	**$50** *copay*	*50% coinsurance after deductible*
Hospital (Hospital-based urgent care) *Benefit reflected in the facility only; the provider charge is separate.*	**$50** *copay*	*50% coinsurance after deductible*
Emergency Room *When admitted to inpatient directly from the ER, the Copay is waived. Same copay applies for In-Network and Out-of-Network.*	**$500** *copay*	$500 *copay*
Ambulance Transportation *Medically necessary emergency air and ground ambulance transport.*	**$500** *copay per trip*	$500 *copay per trip*
Non-Emergency Ambulance *Medically necessary non-emergency ground transport.* *Prior Authorization required.*	**$500** *copay per trip*	$500 *copay per trip*

AMBULATORY SURGICAL CENTER (ASC)	IN-NETWORK[1] *UHN*	*Out-of-Network*
ASC Surgery Facility *Day surgery at an ambulatory surgical center. Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*
Surgeon/Assistant Surgeon *Prior Authorization may be required.*	**$500** *copay*	*50% coinsurance after deductible*
Anesthesiologist *Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*

INPATIENT HOSPITAL & FACILITY	IN-NETWORK[1] *UHN*	*Out-of-Network*
Acute Care Inpatient Facility *Prior Authorization required. Includes **Bariatric Surgery** (1/lifetime), **Inpatient Rehabilitation** (60 visits/condition/year).*	**$1,000** *copay*	*50% coinsurance after deductible*
Inpatient Physician Charges (*Physician charges during a covered inpatient stay.*)	**$0** *copay*	*50% coinsurance after deductible*
Preadmission Testing *Included in admission/surgical copay.*	**$0** *copay*	*50% coinsurance after deductible*
Post-Hospitalization Rehab Facility *Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*
Skilled Nursing Facility *Limit to 100 days/year. Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*
Organ Transplant Services Facility *Center of Excellence (COE) only. Prior Authorization required.*	**$1,000** *copay*	*50% coinsurance after deductible*

OUTPATIENT HOSPITAL SERVICES	IN-NETWORK[1] *UHN*	*Out-of-Network*
Outpatient Hospital Facility *Prior Authorization required if sedation is medically necessary. Includes **Outpatient Mastectomy Reconstructive Surgery** and **TMJ Dysfunction surgical procedures**.*	**$1,000** *copay*	*50% coinsurance after deductible*
Outpatient Hospital Observation *Post-op complications only.*	**$1,000** *copay*	*50% coinsurance after deductible*
Oncology Infusion / Chemotherapy *Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*
Radiation Therapy *Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*
Infusion Therapy *Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*

RSCC CONCIERGE

THERAPY & REHAB OFFICE / STANDALONE CLINIC	**IN-NETWORK**[1] *UHN*	*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 to age 19.*		
In-Office / Freestanding Clinic	**$60** *copay*	*50% coinsurance after deductible*
Hospital Outpatient	**$250** *copay*	*50% coinsurance after deductible*
Autism Spectrum Disorder (ASD) *Applied behavior analysis and related therapies. Up to 1,500 hours per calendar year.*		
In-Office / Freestanding	**$60** *copay*	*50% coinsurance after deductible*
Hospital Outpatient	**$250** *copay*	*50% coinsurance after deductible*
Cardiac Rehab *Prior Authorization required. Limit to phases III & IV.*	**$100** *copay*	*50% coinsurance after deductible*
Pulmonary Rehab / Respiratory Therapy *Limit 30 visits/year.*	**$250** *copay*	*50% coinsurance after deductible*
Spinal Manipulation *Includes all covered services related to spinal manipulation. Up to 26 visits per year.*	**$60** *copay*	*50% coinsurance after deductible*
Infusion Specialty Medications *Prior Authorization required.*	**$500** *copay*	*50% coinsurance after deductible*
Dialysis & Infusion Therapy *Prior Authorization required.* ***Kidney dialysis (renal/ESRD)*** *and* ***non-oncology infusion therapy*** *at a provider's office, freestanding facility, or home-based.*	**$250** *copay*	*50% coinsurance after deductible*

RSCC CONCIERGE

MENTAL HEALTH & SUBSTANCE USE DISORDER	IN-NETWORK[1] *UHN*	*Out-of-Network*
Mental Health & Substance Abuse - Office Visit *Outpatient office and telemedicine visits for mental health and substance use disorder.*	**$0** *copay*	*50% coinsurance after deductible*
Inpatient Mental Health - Facility *Inpatient care for severe mental illness. Prior Authorization required.*	**$1,000** *copay*	*50% coinsurance after deductible*
Inpatient Mental Health - Physician *Physician charges for covered inpatient stay.*	**$0** *copay*	*50% coinsurance after deductible*
Outpatient Mental Health – Facility *Prior Authorization required.*	**$250** *copay*	*50% coinsurance after deductible*
Outpatient Mental Health - Physician	**$0** *copay*	*50% coinsurance after deductible*
Mental Health Residential Treatment *Prior Authorization required.*	**$1,000** *copay*	*50% coinsurance after deductible*
Mental Health Partial Hospitalization *Prior Authorization required.*	**$1,000** *copay*	*50% coinsurance after deductible*
Inpatient Substance Abuse Treatment *Inpatient care for substance abuse detox and rehab. Prior Authorization required.*	**$1,000** *copay*	*50% coinsurance after deductible*
Outpatient Substance Abuse Treatment *Outpatient care for substance abuse detox and rehab. Prior Authorization required.*	**$250** *copay*	*50% coinsurance after deductible*

RSCC CONCIERGE

PRESCRIPTION DRUG COVERAGE	IN-NETWORK RETAIL *30-day supply*	PHARMACY MAIL ORDER *90-day supply*	*Out-of-Network*
Tier 0 – Essential Health Benefits *Vaccines, contraception, smoking cessation medications, and more.*	***$0** copay*	***$0** copay*	*Not covered*
Tier 1 – Generic Drugs *Formulary generic medications.*	**$5** *copay*	**$10** *copay*	*Not covered*
Tier 2 – Preferred Brand Drugs *Formulary preferred brand-name medications.*	**$30** *copay*	**$60** *copay*	*Not covered*
Tier 3 – Non-Preferred Brand Drugs *Formulary non-preferred brand-name medications.*	**$80** *copay*	**$240** *copay*	*Not covered*
Tier 4 – Specialty Drugs *High-cost specialty and biologic medications. Prior Authorization required. Mandatory participation in Manufacturer Assistance Programs (MAP).*	**$500** *copay*	*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.			

MATERNITY / PRENATAL	IN-NETWORK[1] *UHN*	*Out-of-Network*
Routine Pre/Post-Natal Visits *Routine prenatal and post-natal office visits.*	***$0** copay*	*50% coinsurance after deductible*
Inpatient Delivery Room & Well-Baby *Applies to single births; additional newborns billed separately.*	**$1,000** *copay*	*50% coinsurance after deductible*
Delivery Charge / Newborn Physician Services *Applies when billed separately from maternal OB fees.*	**$0** *copay*	*50% coinsurance after deductible*
Nurse Midwife / Birthing Center *Services by licensed professionals/facilities.*	**$0** *copay*	*50% coinsurance after deductible*

PEDIATRIC DENTAL & VISION *18-years and younger*	IN-NETWORK[1] *Guardian*	*Out-of-Network*
Diagnostic and Preventive Dental Services	***$0** copay*	50% coinsurance after deductible
Basic Restorative Dental Procedures *Prior authorization required for anesthesia.*	**20%** *coinsurance*	50% coinsurance after deductible
Major Restorative Dental Procedures *Prior authorization required for anesthesia.*	**50%** *coinsurance*	50% coinsurance after deductible
Orthodontia	**50%** *coinsurance*	50% coinsurance after deductible
Routine Eye Exam *One routine eye exam per year.*	***$0** copay*	50% coinsurance after deductible
Glasses *One pair of basic frames and lenses per year.*	***$0** copay*	50% coinsurance after deductible

RSCC CONCIERGE

OTHER SERVICES	IN-NETWORK[1] *UHN*	*Out-of-Network*
Durable Medical Equipment *Prior Authorization required if more than $1,500.*		
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.*	**$250** *copay*	*50% coinsurance after deductible*
CPAP / BiPAP Equipment & Supplies *Continuous and bilevel positive airway pressure equipment and related supplies.*	**$250** *copay*	*50% coinsurance after deductible*
Prosthetics *Prosthetic devices and medically necessary replacements.*	**$250** *copay*	*50% coinsurance after deductible*
Orthotics *Foot orthotics up to one pair per year. Dental/oral orthotic appliances for TMJ and/or sleep apnea up to one per year.*	**$250** *copay*	*50% coinsurance after deductible*
Hearing Aids *Prescription hearing aid devices, batteries and repairs. One pair per year.*	**$250** *copay*	*50% coinsurance after deductible*
Diabetic Pump & Supplies *Insulin pumps and diabetic supplies from a DME supplier. Insulin: maximum $35 per one-month supply.*	**$100** *copay*	*50% coinsurance after deductible*
Sleep Study *Prior Authorization required.*		
In-Home	**$100** *copay*	*50% coinsurance after deductible*
Freestanding / Clinic	**$250** *copay*	*50% coinsurance after deductible*
Hospital Outpatient	**$1,000** *copay*	*50% coinsurance after deductible*
Home Health Care *Prior Authorization required.* *Skilled nursing, therapy and home health aide visits. Limited to 30 visits per calendar year.*	**$100** *copay*	*50% coinsurance after deductible*
Hospice Care Residential *Home-based and residential hospice visits. Per visit copay.*	**$0** *copay*	*50% coinsurance after deductible*
Hospice Care Inpatient *Hospital inpatient hospice admission when home care is not feasible.*	**$1,000** *copay*	*50% coinsurance after deductible*
Hospice Care Respite *Provides temporary caregiver relief (max 5 consecutive days per break).*	**$0** *copay*	*50% coinsurance after deductible*

RSCC CONCIERGE

OTHER SERVICES (continued)	IN-NETWORK[1] *UHN*	*Out-of-Network*
Genetic Testing *Prior Authorization required.*	**$1,000** *copay*	*50% coinsurance after deductible*
Cochlear Implants *Prior Authorization required. Covered up to the age of 18.*	**$1,000** *copay*	*50% coinsurance after deductible*
Consumable Medical Supplies ***Nutritional Supplements**: Medical-grade nutritional supplements for therapeutic needs. Enteral therapy and parenteral nutrition. Maximum 120-day supply.* ***Ostomy Supplies**: Medically necessary ostomy bags, appliances and related supplies.*	**$100** *copay*	*50% coinsurance after deductible*

Plan disclosures and definitions follow on the next page.

Important Information About Your Plan

This is a Summary Only: This Schedule of Benefits is a brief overview of your coverage. For complete details, definitions, and a full list of what is covered and what is excluded, please refer to your **Evidence of Coverage (EOC)**. If there is a conflict between this summary and the EOC, the EOC will govern.

Prior Authorization May Be Required: Certain services require approval before you receive care. Getting Prior Authorization is a determination of medical necessity, not a guarantee of payment or coverage.

Your Care Decisions: While this document outlines what the Plan will *pay* for, all medical treatment decisions are strictly between you and your healthcare provider. The approval of a Prior Authorization confirms that a service is medically necessary under plan guidelines, but it is not a mandate for treatment.

Network Restrictions & Choosing the Right Provider: You will always save the most money by seeing an In-Network provider. Receiving care from an Out-of-Network provider may result in higher out-of-pocket costs, and you may be responsible for "balance billing"—which is the difference between what the plan allows for a service and what the provider chooses to charge.

Important Note on Your Benefits: Final determination of benefits and coverage is made only after your provider submits a formal claim to us. To receive benefits, your coverage must be active and in effect on the exact day you receive care.

If You Have Other Insurance: If you or your dependents are covered by more than one health insurance plan, your benefits will be coordinated. This ensures that the total payments from all plans do not exceed the actual cost of your medical care. Please notify Member Services immediately if your secondary insurance coverage changes.

How Your Benefits Work and Special Programs

Deductibles and Out-of-Pocket Maximums:

Family Coverage Structure: All cost-shares shown are for individual coverage. Family deductibles and Out-of-Pocket Maximums (OOPM) are twice (2x) the individual amounts, operating under an embedded (non-aggregate) structure.

After the Deductible: Once your deductible is met (where applicable), the plan pays 100% of the allowed amount up to the OOPM—Members pay only the stated copayment or coinsurance.

Out-of-Network (OON) Rules: Out-of-network benefits apply when care is received outside the UHN network.

Important Plan Rules & Restrictions

HSA-Qualified High-Deductible Health Plans (HDHP): For Health Savings Account (HSA)-qualified High-Deductible Health Plans, ALL non-preventive services require the deductible to be satisfied first. IRS rules strictly prohibit any pre-deductible cost-sharing on these plans. Members may use their HSA funds to pay for these pre-deductible expenses.

Specialty Drugs (Tier 4): Specialty medications require Prior Authorization and mandatory participation in Manufacturer Assistance Programs (MAP). Non-compliance limits the benefit to a one-month supply; subsequent refills will be denied.

Unlisted Copayments: Copayment amounts for services not explicitly listed in this Schedule of Benefits are estimated. Please confirm final copayments with Prominence's Care Advocates prior to receiving care.

Definitions and Footnotes

CYD (Calendar Year Deductible): Must be satisfied before coinsurance percentages apply. Copayments 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 the UCR amount.

OOPM (Out-of-Pocket Maximum): Copayments, coinsurance, and deductibles all accrue toward the OOPM. Use of the Emergency Room (ER) for non-emergency conditions does not count toward the OOPM.

1 When traveling or living outside the Prominence UHN service areas, covered services received from providers that do not participate in the Prominence UHN Network will be subject to the plan's Out-Of-Network benefits and may result in higher member costs..

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

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

www.prominencehealthplan.com