Prominence℠ Health Plan

Summary of Benefits

Prominence HealthFirst
Large Group Health Plan

City of Carson POS Rx - 15/40/60

Type of Service	Your Out-of-Pocket Expense HMO In-Network[3]	Your Out-of-Pocket Expense PPO In-Network[2]	Your Out-of-Pocket Expense PPO Out-of-Network[1,2]
Calendar Year Deductible	$1,500 Individual	$3,500 Individual	$4,500 Individual
	$4,500 Family	$10,500 Family	$13,500 Family
Out-of-Pocket Maximums - Deductibles, Coinsurance and Copayments accrue toward the out-of-pocket maximum.	$6,000 (2x Family)	$6,350 Individual	$9,000 Individual
		$12,700 Family	$18,000 Family
Lifetime Maximums	N/A	N/A	N/A
Physician Office Visits			
• Telemedicine services	$20 copay	$20 copay	N/A
• Primary care practitioner (PCP)	$30 per visit PCP	$40 per visit PCP	50% after deductible
• Specialist office visit	$50 per visit Specialist	$60 per visit Specialist	50% after deductible
Alternative Medicine - (Homeopathy, Acupuncture and Integrated Medicine) $1,500 maximum per calendar year - Initial self referral	$30 per visit PCP	$40 per visit PCP	50% after deductible
	$50 per visit Specialist	$60 per visit Specialist	50% after deductible
Ambulance Services			
• Ground	$200 per trip	$200 per trip	$200 per trip
• Air	$200 per trip	$200 per trip	$200 per trip
Diabetic Products	$15 Generic	$15 Generic	Deductible/ 30% Coinsurance
	$40 Preferred	$40 Preferred	Deductible/ 30% Coinsurance
	$60 Non-Preferred	$60 Non-Preferred	Deductible/ 30% Coinsurance
Durable Medical Equipment[4]			
• Rental	Deductible/ $50 copay per item	Deductible/30% coinsurance	Deductible/50% coinsurance
• Items Approved for Purchase	Deductible/ $100 copay per item	Deductible/30% coinsurance	Deductible/50% coinsurance

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Emergency Care			
• Emergency Room (The copay is waived when the member is admitted as an inpatient directly from the Emergency Room)	$150 copay per visit	$150 copay per visit	$150 copay per visit
• Urgent care	$50 copay per visit	$50 copay per visit	$50 copay per visit
Health and Wellness Services			
• Online Wellness Risk Assessment - see www.prominencehealthplan.com for the Health Risk Assessment	No Charge	Not applicable	Not applicable
• Telephonic Health Coaching - 6 sessions per calendar year, per condition (Diabetes Management, Tobacco Cessation and Weight Management.	No Charge	Provided through Prominence	Not applicable
Home Health Care - Maximum 30 visits per calendar year	$30 copay per visit PCP	Covered Under HMO Only	Covered Under HMO Only
	$50 copay per visit Specialist	Covered Under HMO Only	Covered Under HMO Only
Hospice Care	No Charge	30% after deductible	50% after deductible
Hospital/Outpatient/Ambulatory Services			
• Inpatient	Deductible/ $1,000 per admit	30% after deductible	50% after deductible
• Outpatient	$400 copay per admit	30% after deductible	50% after deductible
• Observation[5]	$400 copay per admit	30% after deductible	50% after deductible
• Inpatient Skilled Nursing - Limited to 100 days per calendar year	Deductible/ $1,000 copay per admit	Covered Under HMO Only	Covered Under HMO Only
• Acute Rehabilitation - Limited 60 days per calendar year	Deductible/ $1,000 copay per admit	Covered Under HMO Only	Covered Under HMO Only
Infusion Therapy - Some infused drugs known as Special Pharmaceuticals will require 20% coinsurance.			
Site of infused therapy:			
• Infusion performed and billed by a Physician's Office	$50 copay per visit Specialist	30% after deductible	50% after deductible
• Infusion performed and billed by a hospital outpatient facility	$400 copay per admit	30% after deductible	50% after deductible
Kidney Dialysis Services - Covered to the extent not covered by Medicare	$50 copay per visit Specialist	Covered Under HMO Only	Covered Under HMO Only

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Laboratory and Pathology Services			
• Laboratory	No charge	30% after deductible	50% after deductible
• Pathology	No charge	30% after deductible	50% after deductible
Maternity - 12 copay maximum per pregnancy			
• Physician: Prentatal and Delivery - The $200 copay applies to all obstetrician services associated with the birth.	$200 copay	$300 copay	50% after deductible
• Delivery Room and Nursery Hospital Care for mother and baby	Deductible/ $1,000 copay per admit	30% after deductible	50% after deductible
Medical Nutrition Therapy Counseling - Limited to 25 visits per calendar year.	$30 copay per visit	Covered Under HMO Only	Covered Under HMO Only
Mental Health Services			
Severe Mental Illness			
•Inpatient	Deductible/ $1,000 copay per admit	30% after deductible	50% after deductible
•Day Treatment Program	$400 copay per admit	30% after deductible	50% after deductible
•Outpatient	$400 copay per admit	30% after deductible	50% after deductible
General Mental Health			
•Outpatient	$30 copay per visit	30% after deductible	50% after deductible
Alcohol and Drug Abuse Services			
•Inpatient Withdrawal	Deductible/ $1,000 copay per admit	30% after deductible	50% after deductible
•Inpatient Rehabilitation	Deductible/ $1,000 copay per admit	30% after deductible	50% after deductible
•Outpatient Rehabilitation/Day Treatment	$400 copay per admit	30% after deductible	50% after deductible
•Outpatient	$30 copay per visit PCP	30% after deductible	50% after deductible
Morbid Obesity - Limited to one procedure every three years; includes surgical complications.			
•Bariatric Restrictive Surgery	Deductible/ $1,000 copay per admit	30% after deductible	50% after deductible
Nutritional Supplements, Enteral Therapy and Parenteral Nutrition[7,8]	$30 for a 30 day supply	$30 for a 30 day supply	$30 for a 30 day supply

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Organ Transplants	Deductible/ $1,000 per admit	Covered under HMO Only	Covered under HMO Only
Orthotics - Foot Orthotics limited to one pair, per member, per calendar year	$50 per item	30% after deductible	50% after deductible
Ostomy Supplies - Per 30 day supply	$10 per item	30% after deductible	50% after deductible
Prescription drugs			
• FDA approved oral contraceptive drugs	No charge	No charge	30% after deductible
• Generic	$15 Generic	$15 Generic	30% after deductible
• Preferred Brand	$40 Preferred	$40 Preferred	30% after deductible
• Non-Preferred Brand	$60 Non-preferred	$60 Non-preferred	30% after deductible
• Special Pharmaceuticals	20% coinsurance	20% coinsurance	30% after deductible
PharmacyPlus			
• PharmacyPlus generic[9]	$10 copay	$10 copay	30% after deductible
• PharmacyPlus brand[9]	$35 copay	$35 copay	30% after deductible
Preventive Services			
• Colorectal Cancer Screening - Colonoscopy, Sigmoidoscopy, or Fecal Occult	No charge	30% after deductible	50% after deductible
• Blood Test	No charge	30% after deductible	50% after deductible
• Mammograms - Baseline and annual	No charge	30% after deductible	50% after deductible
• Pap and pelvic exams	No charge	30% after deductible	50% after deductible
• Periodic health assessments for hearing and vision for ages 19 and under.	No charge	30% after deductible	50% after deductible
• Prenatal well visits	No charge	30% after deductible	50% after deductible
• Prostate Screenings	No charge	30% after deductible	50% after deductible
• Well baby, well child visits, immunizations/vaccinations for children through age 17	No charge	30% after deductible	50% after deductible
• Sterilization - preventive only	No charge	30% after deductible	50% after deductible

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Prosthetics	Deductible/$500 copay per item	30% after deductible	50% after deductible
Radiation Oncology Therapy	$50 copay per visit Specialist	30% after deductible	50% after deductible
Radiology and Diagnostic Services[6]			
• Routine diagnostic and X-ray tests performed in an in-network, freestanding facility.	$50 copay per visit	30% after deductible	50% after deductible
• Testing performed in and billed by a hospital outpatient facility.	Deductible/ $250 copay per visit	30% after deductible	50% after deductible
CT SCAN and MRI			
• MRI and CT Scans performed and billed by an in-network, free-standing outpatient facility.	$100 copay per visit	30% after deductible	50% after deductible
• MRI and CT Scans performed and billed by a hospital outpatient facility	Deductible/ $500 copay per visit	30% after deductible	50% after deductible
Complex Diagnostic Testing			
• Complex Diagnostic Testing permored and billed by a in-network, freestanding, outpatient facility.	$200 copay per visit	30% after deductible	50% after deductible
• Complex Diagnostic Testing permored and billed by a hospital outpatient facility.	Deductible/ $1,000 copay per visit	30% after deductible	50% after deductible
Spinal Manipulation	$50 copay per visit Specialist	$60 copay per visit Specialist	50% after deductible
Temporomandibular Joint Disorder (TMJ) and Orthognathic Surgery			
• TMJ Surgery	Deductible/$400 copay per admit	Deductible/30% coinsurance	Deductible/50% coinsurance
• TMJ Non Surgical Outpatient	$50 copay per visit	Deductible/30% coinsurance	Deductible/50% coinsurance
Therapies (Physical, Occupational and Speech)			
• Therapies are limited to 60 visits per condition per member per calendar year.	$50 copay per visit Specialist	30% after deductible	50% after deductible
• Autism Spectrum Disorders - limited to $200 visits per calendar year	$50 copay per visit Specialist	30% after deductible	50% after deductible

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This disclosure statement provides only a brief description of some important features and limitations of your policy. The POS Evidence of Coverage (EOC) sets forth in detail the rights and obligation of both you and the insurance company. It is important you review the EOC once you are enrolled.

For HMO benefits, except for an emergency, all health care services must be coordinated by a Plan Practitioner/ Provider, prior authorized8 by HealthFirstAll PPO In-Network and Non PPO Out-of-Network Maximums are combined.

1. PPO Out-of-Network - Members who obtain Covered Benefits from an Out-of-Network Provider will be responsible for all charges in excess of the Eligible Medical Expense charges. Those charges in excess of the Eligible Medical Expense will not be applied to the Annual Out-of-Pocket Maximum. Eligible Medical Expense Services means the maximum amount the Plan will pay for a Covered Service.
2. The Out-of-Pocket Calendar Maximum for the HMO tier is the combined total expense paid by a Member as deductible and coinsurance and copays for all covered Services in a Calendar Year. It does not include: a) any expenditures for reduction in benefits resulting from a Member's failure to comply with the Medical Management Program; b) any expenses for covered services in excess of Eligible Medical Expense Charges; c) expenses for which no benefits are payable by the Plan; or d) expenses a Member must pay because benefits paid by the Plan have reached the Calendar Year, lifetime, or per illness maximum benefit set forth by the Plan.
3. The Out-of-Pocket Maximums for PPO In-Network and PPO Out-of Network benefits are the combined total expense paid by a Member as Deductible and Coinsurance for all Covered Services in a Calendar Year. It does not include: a) any expenditures for reductions in benefits resulting from a Member's failure to comply with the Medical Management Program; b) any expenses for Covered Services in excess of Usual and Customary Charges; c) expenses for which no benefits are payable by the Plan; or d) expenses a Member must pay because benefits paid by the Plan have reached the Calendar Year, lifetime, or per illness maximum benefit set forth by the Plan.
4. Durable Medical Equipment is covered for inpatient and outpatient, when medically necessary, authorized by HealthFirst and in accordance with Medicare DME guidelines.
5. Ambulatory and day surgery services performed in Hospital or other facility.
6. Some invasive diagnostic procedures require an outpatient hospital copay.
7. Prior Authorization means the process by which a Plan Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Plan Member and obtain approval from the plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment; payment is dependent upon eligibility at the time Covered Services are received.
8. Nutritional supplements limited to 120-day supply per calendar year.
9. Members have the option to fill certain available prescriptions at PharmacyPlus locations for a discounted copay amount. For a complete list of PharmacyPlus locations, please refer to the provider directory. Provider directories can be found online at www.prominencehealthplan.com.

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Patient Protection and Affordable Care Act (PPACA) Mandatory Disclosures

For HealthFirst documents that are Qualified Health Plans1

Choosing your Primary Care Provider

Prominence HealthFirst generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Prominence HealthFirst designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Prominence Member Services at (775) 770-9310 and (800) 863-7515.

Access to Pediatricians

For Children, you may designate a pediatrician as the primary care provider.

Access to OB/GYN Physicians

You do not need prior authorization from Prominence HealthFirst or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Prominence Member Services at (775) 770-9310 and (800) 863-7515.

Rescissions

Prominence HealthFirst will not rescind coverage once a member is enrolled unless the individual(or a person seeking coverage on behalf of the individual) performs an intentional act, practice or omission that constitutes fraud, or unless the individual makes an intentional material misrepresentation of fact, as prohibited by the terms of the Evidence of Coverage. Prominence HealthFirst will provide at least 30 days advance written notice to each participant who would be affected before coverage will be rescinded.

Emergency Services

Emergency Services at Prominence Health Plans are provided as follows:

a. Without prior authorization requirement;
b. Without regard to whether the provider of the services is in-network;
c. If the services are out-of-network, without any administrative requirements or coverage limitations that are more restrictive than those imposed on in-network services; and
d. Without regard to any other term or condition of the coverage other than (1) The exclusion of or coordination of benefits; (2) An affiliation or waiting period permitted under ERISA, the PHSA, or the Internal Revenue Code or (3) Applicable cost sharing..

[1]All "New" or Qualified Health Plans that are in existence beginning on or after September 23, 2010.