2024 SUMMARY of BENEFITS

Benefits effective January 1, 2024

Prominence Health Plan
Prominence Beyond (HMO)

Northern Nevada Region
Carson City, Churchill, Douglas, Lyon and Storey Counties

Y0109_NNVBEYONDSB24_M CMS Accepted

Prominence Health Plan

2024 SUMMARY of BENEFITS

Prominence Beyond (HMO)
H5945, 020 (Northern Nevada Region)

This is a summary of health and drug services covered by Prominence Health Plan for January 1, 2024, through December 31, 2024.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the *2024 Evidence of Coverage* booklet by calling 1-855-969-5882 (TTY users should call 711). You can also view and download the *2024 Evidence of Coverage* booklet at ProminenceMedicare.com.

Prominence Beyond (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services.

Prominence Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in Prominence Health Plan depends on contract renewal.

To join Prominence Beyond (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Nevada:

H5945-020: Carson City, Churchill, Douglas, Lyon and Storey Counties.

For coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. You can view it online at www.medicare.gov or request a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1877-486-2048.)

This document is available in other formats such as Braille or large print.

For more information, please call us at 1-855-969-5882 (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. Calls to this number are free. You can also visit us at: ProminenceMedicare.com.

Prominence Health Plan

Premiums and Benefits	Prominence Beyond (HMO) – 020 Northern Nevada	What you should know
Monthly Plan Premium	$0	You must continue to pay your Medicare Part B premium.
Deductible	$0	This plan has no deductible.
Maximum Out-of-Pocket (Does not include prescription drug costs.)	$6,200 per year.	This is the most you pay for copayments, coinsurance and other costs for medical services covered under your plan.
Inpatient Hospital Coverage	$145-$335 per day for days 1-6.* $0 per day for days 7-90.	Your physician is required to notify the plan when you are admitted.
Outpatient Hospital Coverage Outpatient surgery or other services received in an outpatient hospital setting Observation care Ambulatory surgical center services	 $350 outpatient hospital. $250 observation care. $100 ambulatory surgical center.	Prior authorization is required for outpatient, observation services and ambulatory surgical center services. Minimum copay amount of $25 for Wound Care Treatment at a Provider office, Ambulatory Surgical Center and contracted Wound Care Facility.
Doctor Visits Primary care providers Specialists	 $0 Primary care visit. $45 Specialist visit.	Prior authorization may be required for specialist visits.
Preventive Care	$0 for Original Medicare preventive services.	Any additional preventive services approved by Medicare during the contract year will be covered. For more information, please see Chapter 4: “Medical Benefits Chart (what is covered and what you pay)” in the *2024 Evidence of Coverage*.
Annual Physical Exam	$0	You may have copayments for screening exams and/or diagnostic tests received before or after this visit.

Premiums and Benefits	Prominence Beyond (HMO) – 020 Northern Nevada	What you should know
Emergency Care	$80 Freestanding emergency facility. $120 Other emergency facilities. $125 for emergency services outside the United States.	The copayment will be waived if you are admitted to the hospital as an inpatient for the same condition within three days of an emergency care visit. Annual maximum coverage amount of $50,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures.
Urgent Care	$50 per visit. $30 outside the United States.	The copayment will be waived if you are admitted to the hospital as an inpatient for the same condition within three days of an urgent care visit. Annual maximum coverage amount of $50,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures.
Diagnostic Services/Labs/Imaging Diagnostic procedures/ tests and lab services Diagnostic radiological services (such as CT scans, MRIs) Therapeutic radiological services Outpatient x-rays	 $0 for diagnostic procedures. $60 - $100* for diagnostic radiological services (e.g., CT scans and MRIs). *Copay will depend on facility used. $35 for therapeutic radiological services. $0 for x-rays.	Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.

Premiums and Benefits	Prominence Beyond (HMO) – 020 Northern Nevada	What you should know
Hearing Services	$0 routine hearing exam for hearing aids. One exam per year. $10 Medicare-covered hearing services. (Diagnostic hearing and balance exams.) $800 toward hearing aids per year (per ear).	You are responsible for any amount over the hearing aid coverage limit. All hearing aids must be purchased through Hearing Care Solutions. Schedule appointments through Hearing Care Solutions at 866-344- 7756. Prior authorization and referrals not required.
Dental Services - Medicare-covered	$0	Prior authorization and referrals not required.
Dental Services - preventive and comprehensive (Included Dental Plan)	Preventive and comprehensive dental services are included with no additional monthly premium. Covered services include: teeth cleaning - 2 per year oral exam - 2 per year dental x-rays, once a year non-routine services diagnostic services restorative services endodontics periodontics extractions prosthodontics – including implants oral/maxillofacial surgery	No deductible, copayment or coinsurance. $4,000 per year maximum coverage for preventive and comprehensive dental services combined. You are responsible for any amount over the dental coverage limit. You must use Delta Dental Medicare Advantage PPO network of providers.
Dental - Optional Supplemental (Premium Dental Plan)	$7,500 total allowance for preventive and comprehensive dental. $32 monthly premium.	Expanded network of dentists plus extra crowns and extractions above base dental plan coverage.

Premiums and Benefits	Prominence Beyond (HMO) – 020 Northern Nevada	What you should know
Vision Services	$0 for routine eye exam (eye exams for glasses or contacts). One exam per year. $30 for Medicare-covered eye exams (exams to diagnose and treat diseases and conditions of the eye). $500 annual allowance for eyewear.	You must use the National Vision Administrators (NVA) vision network of providers. Prior authorization and referrals not required.
Mental Health Services Inpatient visit Outpatient therapy visit Partial hospitalization	 $330 per day, days 1-5. $0 per day, days 6-90. $35 for individual or group therapy. $55 per day for partial hospitalization services.	For inpatient mental healthcare stays, your physician is required to notify the plan when you are admitted. Prior authorization is required for partial hospitalization services.
Skilled Nursing Facility	$0 per day, days 1–20. $203 per day, days 21–100.	Prior authorization is required.
Physical Therapy	$50 per visit.	Prior authorization is required for visits over 12 annually.
Ambulance	You pay $300 per transportation segment.	A segment is transport by ambulance to the nearest appropriate facility. If you are then transported by ambulance to another facility, you will pay for another segment. Prior authorization required for non-emergency transport. Copayment waived if you are admitted to the hospital as an inpatient.

Premiums and Benefits	Prominence Beyond (HMO) – 020 Northern Nevada	What you should know
Transportation Health-related Non-health related	$0 for plan-approved transportation services. Unlimited one-way trips to plan-approved health-related locations each calendar year. Up to 20 one-way trips to plan approved non-medical locations including grocery shopping, banking, fitness, community centers, and other social events.	Unlimited one-way trips to plan-approved health-related locations each year. Mileage limits may apply. Prior authorization required. To use the non-medical transportation benefit you must: 1) Be enrolled in a care management program with the plan. 2) Use this plan's contracted transportation providers. 3) Schedule transports 72 hours in advance.
Medicare Part B Drugs	0-20% of the total cost of chemotherapy and other Part B drugs.	Prior authorization may be required.
Medical Equipment/ Supplies Durable medical equipment (DME) (e.g., wheelchairs, oxygen) Prosthetics (e.g., braces, artificial limbs) and medical supplies Diabetic supplies	 20% of total cost. 20% of total cost. $0 of the total cost of diabetic supplies, including meters and test strips. 20% of the total cost of diabetic therapeutic shoes or inserts.	Prior authorization is required for durable medical equipment, prosthetics, medical supplies and diabetic therapeutic shoes or inserts. The only covered blood glucose monitors and test strips are CONTOUR® products. (No authorization is required unless quantity greater than 150 strips per 30-day supply is requested.) Continuous glucose monitoring supplies require prior authorization. The only brand covered is FREESTYLE LIBRE® products. Other brands require prior authorization and medical necessity. Coverage limited to one meter or continuous glucose monitor for every 365 days.

Premiums and Benefits	Prominence Beyond (HMO) – 020 Northern Nevada	What you should know
Podiatry Services (Foot care)	$20 for routine foot care. $35 for Medicare-covered podiatry services. $35 for diabetic foot care.	Limit of 12 visits per year for routine care. Prior authorization is required for all.
Chiropractic Care	$20 for routine chiropractic care. $20 for Medicare-covered chiropractic services.	Limit of 12 visits per year for routine care. Prior authorization is required for all.
Meal Program (Post-hospital discharge)	$0	You may qualify for up to 84 meals delivered to you over a 28-day period depending on your need. Prior authorization is required.
Food Benefit	Members with End-Stage Renal Disease may qualify for $250 per month.	Prior authorization and Care Coordination approval may be required.
Fitness Benefit (The Silver&Fit® Healthy Aging and Exercise Program)	$0	Access to fitness center membership at a participating network location. Option to select a Home Fitness kit, including, Fitbit, Garmin, yoga, strength kits and more.
Over-the-Counter (OTC) medications and products	$110 quarterly allowance.	Unused balances do not carry over to the next period.
Telehealth Services	$0 for medical care and mental health services.	For primary care physician services and individual sessions for mental health specialty services through Teladoc.

In-Network Retail Pharmacy Outpatient Prescription Drugs (30-day Supply)*	
Yearly deductible stage	$545 Deductible applies to tiers 3, 4 and 5 only.
Initial coverage stage	
Tier 1: Preferred Generic	You pay $0.
Tier 2: Generic	You pay $12.
Tier 3: Preferred Brand	You pay $35.
Tier 4: Non-preferred Drugs	You pay $100.
Tier 5: Specialty Drugs	You pay 25% of the total cost.
Tier 6: Select Care Drugs	You pay $0.
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached $5,030.)	For drugs in Tiers 3, 4 and 5, you pay: • 25% of the total cost of brand name drugs. • 25% of the total cost of generic drugs. Tier 1, 2 and 6 drugs are covered in the gap.
Catastrophic coverage stage (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach $8,000.)	Once you have reached the catastrophic phase you pay $0 for your Part D prescriptions.

*Prescription drugs may be up to a 100-day supply.
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

Mail Order Outpatient Prescription Drugs (100-day Supply)*	
Yearly deductible stage	$545 Deductible applies to tiers 3, 4 and 5 only.
Initial coverage stage Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-preferred Drugs Tier 5: Specialty Drugs Tier 6: Select Care Drugs	 You pay $0. You pay $24. You pay $70. You pay $300. Not available. You pay $0.
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached $5,030.)	For drugs in Tiers 3, 4 and 5, you pay: • 25% of the total cost of brand name drugs. • 25% of the total cost of generic drugs. Tier 1, 2 and 6 drugs are covered in the gap.
Catastrophic coverage stage (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach $8,000.)	Once you have reached the catastrophic phase you pay $0 for your Part D prescriptions.

Cost sharing may change when you enter another phase of the Part D benefit. For more specific information on the phases of the benefit, please call us or access our *2024 Evidence of Coverage* online at ProminenceMedicare.com.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 855-969-5882 (TTY: 711), 8 a.m. to 8 p.m., seven days a week from October 1 to March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30.

Understanding the Benefits

- ❑ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit ProminenceMedicare.com or call 855-969-5882 (TTY: 711) to view a copy of the EOC.
- ❑ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ❑ Review the pharmacy directory to make sure the pharmacy you use for any prescription drugs is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ❑ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ❑ Benefits, premiums and/or copayments/coinsurance may change on January 1 of each plan year.
- ❑ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ❑ If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE®, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE® for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Prominence® Health Plan

Prominence Health Plan is an HMO plan with a Medicare contract. Enrollment in Prominence Health Plan depends on contract renewal.

This information is not a complete description of benefits. For more information, call 1-855-969-5882 (TTY:711) 8:00 a.m. to 8:00 p.m., seven days a week from October 1 to March 31 and Monday through Friday from April 1 to September 30.

Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

View our *Provider and Pharmacy Directory* on our website at: ProminenceMedicare.com.

You can see the complete plan *Formulary* (list of Part D prescription drugs) and any restrictions on our website at ProminenceMedicare.com.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-969-5882 (TTY: 711).