

2024 SUMMARY of BENEFITS

Benefits effective January 1, 2024

Prominence Health Plan

Prominence Dual (HMO D-SNP)

Northern Nevada Region

Carson City, Churchill, Douglas, Lyon and Storey
Counties

2024 SUMMARY of BENEFITS

Prominence Dual (HMO D-SNP)
H5945, 017 (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](https://www.ProminenceMedicare.com).

Prominence Dual (HMO D-SNP) 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 Dual (HMO D-SNP), 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:

H5945-002: Carson City, Churchill, Douglas, Lyon and Storey.

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 4877-486-2048.)

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](https://www.ProminenceMedicare.com).

Premiums and Benefits	Prominence Dual (HMO D-SNP) – 017 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.)	\$8,850 per year.	This is the most you pay for copayments, coinsurance and other costs for medical services covered under your plan. Because there are no copayments for this plan members will not reach this limit.
Inpatient Hospital Coverage	\$0 per day.	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	\$0 for outpatient hospital. \$0 for all services during observation care. \$0 for services received at an ambulatory surgical center.	Prior authorization is required for outpatient, observation services and ambulatory surgical center services.
Doctor Visits Primary care providers Specialists	\$0 Primary care visit. \$0 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 <i>2024 Evidence of Coverage</i> .
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 Dual (HMO D-SNP) – 017 Northern Nevada	What you should know
Emergency Care	\$0 per visit. \$0 for emergency service visits outside of the United States.	Annual maximum coverage amount of \$25,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures.
Urgent Care	\$0 per visit. \$0 for an urgent care visit outside the United States.	Annual maximum coverage amount of \$25,000 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. \$0 diagnostic radiological services (e.g., CT scans and MRIs). \$0 for therapeutic radiological services. \$0 for x-rays.	Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.
Hearing Services	\$0 routine hearing exam for hearing aids. One exam per year. \$0 Medicare -covered hearing services. (Diagnostic hearing and balance exams.) Annual maximum coverage amount of \$3,000 for hearing aids (both ears combined) applies.	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.

Premiums and Benefits	Prominence Dual (HMO D-SNP) – 017 Northern Nevada	What you should know
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 oral/maxillofacial surgery	No deductible, copayment or coinsurance. \$2,000 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 the Delta Dental Medicare Advantage PPO network of providers.
Vision Services	\$0 for routine eye exam (eye exams for glasses or contacts). One exam per year. \$0 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	\$0 for inpatient mental health stays.	For inpatient mental healthcare stays, your physician is required to notify the plan when you are admitted.
Outpatient therapy visit	\$0 for individual or group therapy.	Prior authorization is required for individual or group psychiatric sessions; prior authorization is not required for mental health specialty services from a non-physician provider.
Partial hospitalization	\$0 per day for partial hospitalization services.	Prior authorization is required for partial hospitalization services.

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Skilled Nursing Facility	\$0 for skilled nursing facility.	Prior authorization is required.
Physical Therapy	\$0 per visit.	Prior authorization is required.
Ambulance	You pay \$0 per transportation segment.	<p>A segment is transport by ambulance to the nearest appropriate facility.</p> <p>If you are then transported by ambulance to another facility, you will pay for another segment.</p> <p>Prior authorization required for non-emergency transport.</p>
Transportation Health-related Non-health related	<p>\$0 for plan-approved transportation services.</p> <p>Unlimited one-way trips to plan-approved health-related locations every calendar year.</p> <p>Up to 20 one-way trips to plan approved non-medical locations including grocery shopping, banking, fitness, community centers, and other social events.</p>	<p>Mileage limits may apply.</p> <p>Prior authorization required.</p> <p>To use the non-medical transportation benefit you must:</p> <ol style="list-style-type: none"> 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	You pay \$0 for chemotherapy and other Part B drugs.	Prior authorization may be required for Part B drugs.

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<p>Medical Equipment/Supplies</p> <p>Durable medical equipment (DME) (e.g., wheelchairs, oxygen)</p> <p>Prosthetics (e.g., braces, artificial limbs) and medical supplies</p> <p>Diabetic supplies</p>	<p>You pay \$0 for durable medical equipment.</p> <p>You pay \$0 for prosthetic devices and medical supplies.</p> <p>You pay \$0 for diabetic supplies, including meter and test strips.</p> <p>You pay \$0 for diabetic therapeutic shoes or inserts.</p>	<p>Prior authorization is required for durable medical equipment, prosthetics, medical supplies and diabetic therapeutic shoes or inserts.</p> <p>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.)</p> <p>Continuous glucose monitoring supplies require prior authorization. The only brand covered is FREESTYLE LIBRE® products.</p> <p>Other brands require prior authorization and medical necessity.</p> <p>Coverage limited to one meter or continuous glucose monitor for every 365 days.</p>
<p>Podiatry Services (Foot care)</p>	<p>\$0 for routine foot care.</p> <p>\$0 for Medicare-covered podiatry services.</p> <p>\$0 for diabetic foot care.</p>	<p>Limit of 12 visits per year for routine care.</p> <p>Prior authorization is required for all.</p>
<p>Chiropractic Care</p>	<p>\$0 for routine chiropractic care.</p> <p>\$0 for Medicare-covered chiropractic services.</p>	<p>Limit of 12 visits per year for routine care.</p> <p>Prior authorization is required for all.</p>
<p>Meal Program (Post-hospital discharge)</p>	<p>\$0</p>	<p>You may qualify for up to 42 meals delivered to you over a 14-day period depending on your need. Prior authorization is required.</p>

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Food Benefit	<p>Members with End-Stage Renal Disease may qualify for \$250 per month.</p> <p>Members with other chronic conditions (e.g., hypertension, diabetes and more) may qualify for \$20 per month.</p>	<p>Prior authorization and Care Coordination approval may be required.</p> <p>Other chronic conditions include: Autoimmune disorders, cancer, cardiovascular disorders, chronic and disabling mental health conditions, chronic alcohol and other drug dependence, chronic heart failure, chronic lung disorders, dementia, diabetes, end-stage liver disease, heart arrhythmias, HIV/AIDS, hypertension, morbid obesity, neurologic disorders, severe hematologic disorders, stroke.</p>
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	\$100 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	No deductible.
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 \$0. You pay \$0. You pay \$0. You pay \$0. You pay \$0.
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached \$5,030.)	You pay \$0.
Catastrophic coverage stage (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach \$8,000.)	You pay \$0.

*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	No deductible.
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 \$0. You pay \$0. You pay \$0. Not available You pay \$0.
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached \$5,030.)	You pay \$0.
Catastrophic coverage stage (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach \$8,000.)	You pay \$0.

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](https://www.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 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).