

2027 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Prominence Plus (HMO) H7680-001

Prominence Giveback (HMO) H7680-012

Prominence Beyond (HMO-POS) H7680-019

North Texas Region - Standard Plans

Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter and Randall Counties.

January 1, 2027 – December 31, 2027

1

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, call us and ask for the “**Evidence of Coverage**.” You can also see the Evidence of Coverage on our website, www.prominencemedicare.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Prominence Plus (HMO)**, **Prominence Giveback (HMO)** and **Prominence Beyond (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Prominence Plus (HMO)**, **Prominence Giveback (HMO)** and **Prominence Beyond (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Prominence Plus (HMO)**, **Prominence Giveback (HMO)** and **Prominence Beyond (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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

This document may be available in a non-English language. For additional information, call us at 1-855-969-5882 (TTY: 711).

Things to Know About Prominence Plus (HMO), Prominence Giveback (HMO) and Prominence Beyond (HMO-POS)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-855-969-5882, TTY: 711.
- If you are not a member of this plan, call us at 866-747-8855, TTY: 711.
- Our website: www.prominencemedicare.com.

Who can join?

To join **Prominence Plus (HMO), Prominence Giveback (HMO) and Prominence Beyond (HMO-POS)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service areas for **Prominence Plus (HMO), Prominence Giveback (HMO) and Prominence Beyond (HMO-POS)** include the following counties in Texas: Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter and Randall Counties.

Which doctors, hospitals, and pharmacies can I use?

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

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.prominencemedicare.com).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.prominencemedicare.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact
Prominence Health**

2

SECTION II - SUMMARY OF BENEFITS

Prominence Plus (HMO)

Prominence Giveback (HMO)

Prominence Beyond (HMO-POS)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	You do not pay a separate monthly plan premium for Prominence Plus (HMO). You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for Prominence Giveback (HMO). You will receive a \$140 monthly credit towards your Medicare Part B premium. You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for Prominence Beyond (HMO-POS). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$0 deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$0 deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$0 deductible
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: \$3,000 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	Your yearly limit(s) in this plan: \$7,000 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	Your yearly limit(s) in this plan: \$4,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Inpatient Hospital	In-Network: Tier 1: Days 1-5: \$75 copay per day. Days 6-90: \$0 copay per day. Tier 2: Days 1-5: \$250 copay per day. Days 6-90: \$0 copay per day. Your physician is required to notify the plan when you are admitted.	In-Network: Tier 1: Days 1-6: \$275 copay per day. Days 7-90: \$0 copay per day. Tier 2: Days 1-6: \$375 copay per day. Days 7-90: \$0 copay per day. Your physician is required to notify the plan when you are admitted.	In-Network: Tier 1: Days 1-5: \$200 copay per day. Days 6-90: \$0 copay per day. Tier 2: Days 1-5: \$400 copay per day. Days 6-90: \$0 copay per day. Your physician is required to notify the plan when you are admitted.
Outpatient Hospital	In-Network: Wound Care: \$25 copay. All Other Services: \$350 copay.Observation Services: \$125 copay. May require prior authorization.	In-Network: Wound Care: \$25 copay. All Other Services: \$350 copay.Observation Services: \$295 copay. May require prior authorization.	In-Network: Wound Care: \$25 copay. All Other Services: \$475 copay.Observation Services: \$150 copay. May require prior authorization.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Ambulatory Surgical Center	In-Network: Ambulatory Surgical Center: \$25 copay. May require prior authorization.	In-Network: Ambulatory Surgical Center: \$25 copay. May require prior authorization.	In-Network: Ambulatory Surgical Center: \$25 copay. May require prior authorization.
Doctor's Office Visits	In-Network: Primary care physician visit: \$0 copay. Specialist visit: \$25 Copay. Referrals and prior authorization may be required for specialist visits.	In-Network: Primary care physician visit: \$0 copay. Specialist visit: \$45 Copay. Referrals and prior authorization may be required for specialist visits.	In-Network: Primary care physician visit: \$0 copay. Specialist visit: \$45 Copay. 50% coinsurance OON. Referrals and prior authorization may be required for specialist visits.
Preventive Care (e.g., flu vaccine, diabetic screenings)	In-Network: \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	In-Network: \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	In-Network: \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Emergency Care	In-Network: \$150 copay per visit. If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: \$150.00, waived if admitted to the hospital. Annual maximum coverage amount of \$25,000 applies for emergency services and urgent care visits outside the United States.	In-Network: \$130 copay per visit. If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: \$130.00, waived if admitted to the hospital. Annual maximum coverage amount of \$25,000 applies for emergency services and urgent care visits outside the United States.	In-Network: \$130 copay per visit. If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: \$130.00, waived if admitted to the hospital. Annual maximum coverage amount of \$25,000 applies for emergency services and urgent care visits outside the United States.
Urgently Needed Services	In-Network: \$30 copay per visit. Members will not be required to pay the urgent care copay if admitted to the hospital as an inpatient for the same condition within 3 days of an urgent care visit. Worldwide Urgent Care: \$30.00, waived if admitted to the hospital.	In-Network: \$20 copay per visit. Members will not be required to pay the urgent care copay if admitted to the hospital as an inpatient for the same condition within 3 days of an urgent care visit. Worldwide Urgent Care: \$30.00, waived if admitted to the hospital.	In-Network: \$30 copay per visit. Members will not be required to pay the urgent care copay if admitted to the hospital as an inpatient for the same condition within 3 days of an urgent care visit. Worldwide Urgent Care: \$30.00, waived if admitted to the hospital.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Diagnostic Services / Labs/ Imaging	In-Network: Diagnostic tests and procedures: \$0 copay. Lab services: \$0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): \$60 copay. X-rays: \$0 copay. Therapeutic radiology services: 20% coinsurance. May require prior authorization.	In-Network: Diagnostic tests and procedures: \$0 copay. Lab services: \$0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): \$175 copay. X-rays: \$0 copay. Therapeutic radiology services: 20% coinsurance. May require prior authorization.	In-Network: Diagnostic tests and procedures: \$0 copay. Lab services: \$0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): \$60 copay. X-rays: \$0 copay. Therapeutic radiology services: 20% coinsurance. May require prior authorization.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Hearing Services	In-Network: Medicare-covered hearing exam: \$10.00 Copay. Routine hearing exam: \$0 Copay. Hearing Aid: \$600 toward hearing aids per year (Per ear). Members must utilize TruHearing network for hearing aid purchase and routine exams. Hearing aid purchases outside of TruHearing network requires payment upfront to the provider/supplier. Then, submit a request for direct member reimbursement to the health plan for administration of Hearing Aid benefits.	In-Network: Medicare-covered hearing exam: \$10.00 Copay. Routine hearing exam: \$0 Copay. Hearing Aid: \$600 toward hearing aids per year (Per ear). Members must utilize TruHearing network for hearing aid purchase and routine exams. Hearing aid purchases outside of TruHearing network requires payment upfront to the provider/supplier. Then, submit a request for direct member reimbursement to the health plan for administration of Hearing Aid benefits.	In-Network: Medicare-covered hearing exam: \$10.00 Copay. Routine hearing exam: \$0 Copay. Hearing Aid: \$600 toward hearing aids per year (Per ear). Members must utilize TruHearing network for hearing aid purchase and routine exams. Hearing aid purchases outside of TruHearing network requires payment upfront to the provider/supplier. Then, submit a request for direct member reimbursement to the health plan for administration of Hearing Aid benefits.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Dental Services – Included Services	In Network: \$2,000 combined limit maximum coverage preventive and comprehensive dental services combined. Preventive Dental Services: Oral Exams (up to 2 visits every year): \$0 Copay Dental X-Rays (up to 2 visits every year): \$0 Copay Cleaning (up to 2 visits every year): \$0 Copay Fluoride Treatment (up to 2 visits every year): \$0 Copay Comprehensive Dental Services: Restorative Services: min 0% / max 50% coinsurance Fillings – Amalgam restorations, resin-based composites (1 per surface, per tooth every 12 months) This plan does not provide coverage for crowns Endodontics: min 0% / max 50% coinsurance Root canals and related treatments – Endodontic therapy, pulp cap, retreatment of endodontic therapy Periodontics: min 0% / max 50% coinsurance	In Network: \$750 combined limit maximum coverage preventive and comprehensive dental services combined. Preventive Dental Services: Oral Exams (up to 2 visits every year): \$0 Copay Dental X-Rays (up to 2 visits every year): \$0 Copay Cleaning (up to 2 visits every year): \$0 Copay Fluoride Treatment (up to 2 visits every year): \$0 Copay Comprehensive Dental Services: Restorative Services: min 0% / max 50% coinsurance Fillings – Amalgam restorations, resin-based composites (1 per surface, per tooth every 12 months) This plan does not provide coverage for crowns Endodontics: min 0% / max 50% coinsurance Root canals and related treatments – Endodontic therapy, pulp cap, retreatment of endodontic therapy Periodontics: min 0% / max 50% coinsurance Deep cleanings and gum disease treatment – Periodontal scaling and root planing, gingivectomy (1 per quad every 24 months) Full mouth debridement	In Network: \$3,050 combined limit maximum coverage preventive and comprehensive dental services combined. Preventive Dental Services: Oral Exams (up to 2 visits every year): \$0 Copay Dental X-Rays (up to 2 visits every year): \$0 Copay Cleaning (up to 2 visits every year): \$0 Copay Fluoride Treatment (up to 2 visits every year): \$0 Copay Comprehensive Dental Services: Restorative Services: min 0% / max 50% coinsurance Fillings – Amalgam restorations, resin-based composites (1 per surface, per tooth every 12 months) Onlays, crowns (1 per tooth every 60 months) Core buildups Endodontics: min 0% / max 50% coinsurance Root canals and related treatments – Endodontic therapy, pulp cap, retreatment of endodontic therapy, apicoectomy Periodontics: min 0% / max 50% coinsurance Deep cleanings and gum disease treatment – Periodontal scaling and root planing, gingivectomy 1 per quad every 24 months) Full mouth debridement

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
	Deep cleanings and gum disease treatment – Periodontal scaling and root planing, gingivectomy (1 per quad every 24 months) Full mouth debridement Periodontal maintenance 1 every 6 months) Prosthodontics: min 0% / max 50% coinsurance Dentures, denture repairs – Removable Prosthodontics – Complete dentures, partial dentures (1 per arch every 60 months) Denture repair, relines, tissue conditioning (1 per arch every calendar year) Overdentures Bridges and Retainer Crown related services – Fixed Prosthodontics – Pontic, retainer crown (1 per tooth every 60 months) Re-cement of fixed partial denture (1 per site every 12 months) Oral and Maxillofacial Surgery: min 0% / max 50% coinsurance Extractions and related treatment - Extractions, impacted tooth removal Alveoloplasty (1 per quad every 60 months)	Periodontal maintenance (1 every 6 months) Prosthodontics: min 0% / max 50% coinsurance Dentures, denture repairs – Removable Prosthodontics – Complete dentures, partial dentures (1 per arch every 60 months) Denture repair, relines, tissue conditioning (1 per arch every calendar year) Overdentures Bridges and Crown related services – Fixed Prosthodontics – Pontic, retainer crown (1 per tooth every 60 months) Re-cement of fixed partial denture (1 per site every 12 months) Oral and Maxillofacial Surgery: min 0% / max 50% coinsurance Extractions and related treatment – Extractions, impacted tooth removal Alveoloplasty (1 per quad every 60 months) Adjunctive General Services: min 0% / max 50% coinsurance Palliative treatment, sedation, nitrous, consultation, teledentistry Prior authorization may be required Frequencies and Limitations may apply Members must utilize Liberty Dental network of providers. (See EOC for more details).	Periodontal maintenance (1 every 6 months) Prosthodontics: min 0% / max 50% coinsurance Dentures, denture repairs – Removable Prosthodontics – Complete dentures, partial dentures (1 per arch every 60 months) Denture repair, relines, tissue conditioning (1 per arch every calendar year) Bridges and Retainer Crown related services – Fixed Prosthodontics – Pontic, retainer inlay, retainer onlay, retainer crown (1 per tooth every 60 months) Re-cement of fixed partial denture (1 per site every 12 months) Oral and Maxillofacial Surgery: min 0% / max 50% coinsurance Extractions and related treatment – Extractions, impacted tooth removal Alveoloplasty (1 per quad every 60 months) Incision and drainage of abscess Adjunctive General Services: min 0% / max 50% coinsurance Palliative treatment, sedation, nitrous, consultation, teledentistry Prior authorization may be required Frequencies and Limitations may apply

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
	Adjunctive General Services: min 0% / max 50% coinsurance Palliative treatment, sedation, nitrous, consultation, teledentistry Prior authorization may be required Frequencies and Limitations may apply Members must utilize Liberty Dental network of providers. (See EOC for more details).		Members must utilize Liberty Dental network of providers. (See EOC for more details).

COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)

	In-Network:	In-Network:	In-Network:
Vision Services	Medicare-covered vision exam: \$30.00 Copay. Routine eye exam (up to 1 visit every year): \$0 Copay. Eyeglasses (frames and lenses): Our plan pays up to \$150 every year for eyewear. Must utilize National Vision Administrators (NVA) vision network of providers.	Medicare-covered vision exam: \$30.00 Copay. Routine eye exam (up to 1 visit every year): \$0 Copay. Eyeglasses (frames and lenses): Our plan pays up to \$100 every year for eyewear. Must utilize National Vision Administrators (NVA) vision network of providers.	Medicare-covered vision exam: \$30.00 Copay. Routine eye exam (up to 1 visit every year): \$0 Copay. Eyeglasses (frames and lenses): Our plan pays up to \$150 every year for eyewear. Must utilize National Vision Administrators (NVA) vision network of providers.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Mental Health Care	In-Network: Outpatient group therapy visit: \$10 copay. Individual therapy visit: \$10 copay. Inpatient Mental Health Care: \$330 copay per day, for days 1-5. \$0 copay per day for days 6-90. Partial Hospitalization: \$55 copay. Prior Authorization is required for physician services.	In-Network: Outpatient group therapy visit: \$30 copay. Individual therapy visit: \$30 copay. Inpatient Mental Health Care: \$330 copay per day, for days 1-5. \$0 copay per day for days 6-90. Partial Hospitalization: \$55 copay. Prior Authorization is required for physician services.	In-Network: Outpatient group therapy visit: \$10 copay. Individual therapy visit: \$10 copay. Inpatient Mental Health Care: \$330 copay per day, for days 1-5. \$0 copay per day for days 6-90. Partial Hospitalization: \$55 copay. Prior Authorization is required for physician services.
Skilled Nursing Facility (SNF)	In-Network: Days 1-20: \$20 copay per day. Days 21-100: \$221 copay per day. May require prior authorization.	In-Network: Days 1-20: \$10 copay per day. Days 21-100: \$221 copay per day. May require prior authorization.	In-Network: Days 1-20: \$10 copay per day. Days 21-100: \$221 copay per day. May require prior authorization.
Outpatient Rehabilitation	In-Network: Occupational therapy visit: \$5 copay. Physical therapy and speech and language therapy visit: \$20 copay. Prior authorization is required for visits over 12 annually.	In-Network: Occupational therapy visit: \$10 copay. Physical therapy and speech and language therapy visit: \$10 copay. Prior authorization is required for visits over 12 annually.	In-Network: Occupational therapy visit: \$5 copay. Physical therapy and speech and language therapy visit: \$10 copay. Prior authorization is required for visits over 12 annually.

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Ambulance	In-Network: \$250 copay per segment. A segment is transport by ambulance to the nearest appropriate facility. Copayment is waived if you are admitted to the hospital as an inpatient. Prior authorization required for non-emergency transport.	In-Network: \$325 copay per segment. A segment is transport by ambulance to the nearest appropriate facility. Copayment is waived if you are admitted to the hospital as an inpatient. Prior authorization required for non-emergency transport.	In-Network: \$300 copay per segment. A segment is transport by ambulance to the nearest appropriate facility. Copayment is waived if you are admitted to the hospital as an inpatient. Prior authorization required for non-emergency transport.
Transportation	In-Network: \$0 copay. Limit 24/Year trips to plan-approved health-related locations. Mileage limits may apply.	In-Network: Not Covered.	In-Network: Not Covered.
Medicare Part B Drugs	In-Network: For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. (Insulin max \$35) May require prior authorization.	In-Network: For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. (Insulin max \$35) May require prior authorization.	In-Network: For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. (Insulin max \$35) May require prior authorization.

Additional Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Chiropractic Care	In-Network: Routine Chiropractic Care: Not Covered. Medicare Covered Chiropractic Care: \$10 copay.	In-Network: Routine Chiropractic Care: Not Covered. Medicare Covered Chiropractic Care: \$15 copay.	In-Network: Routine Chiropractic Care: \$20 Copay per visit; 12 routine visits every year. Medicare Covered Chiropractic Care: \$10 copay.

Additional Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Fitness Benefit	In-Network: \$0 copay per month. Must utilize gym within Silver & Fit network.	In-Network: \$0 copay per month. Must utilize gym within Silver & Fit network.	In-Network: \$0 copay per month. Must utilize gym within Silver & Fit network.
Foot Care	In-Network: Routine Foot Care: Not Covered. Medicare Covered Podiatry: \$5 copay.	In-Network: Routine Foot Care: Not Covered. Medicare Covered Podiatry: \$40 copay.	In-Network: Routine Foot Care: Not Covered. Medicare Covered Podiatry: \$5 copay.
Medical Equipment/Supplies	In-Network: Durable medical equipment and prosthetics: 20% coinsurance. Diabetes monitoring supplies: 0% coinsurance. Only covered monitors and test strips are Contour products. Alternate brands require prior authorization.	In-Network: Durable medical equipment and prosthetics: 20% coinsurance. Diabetes monitoring supplies: 0% coinsurance. Only covered monitors and test strips are Contour products. Alternate brands require prior authorization.	In-Network: Durable medical equipment and prosthetics: 20% coinsurance. Diabetes monitoring supplies: 0% coinsurance. Only covered monitors and test strips are Contour products. Alternate brands require prior authorization.
Virtual Doctor's Visits Telemedicine	In-Network: \$0 Copay per visit. See a primary care or behavioral health provider using your computer or mobile device through Teladoc. (See EOC for more details).	In-Network: \$0 Copay per visit. See a primary care or behavioral health provider using your computer or mobile device through Teladoc. (See EOC for more details).	In-Network: \$0 Copay per visit. See a primary care or behavioral health provider using your computer or mobile device through Teladoc. (See EOC for more details).

Additional Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO- POS)
Extra Benefit Card	In-Network: \$125 per Quarter for over the counter (OTC) drugs and supplies. OTC products are available through catalog, certain retailers in store or online with andmorehealth.com . Unused balances do not carry over to the next period.	In-Network: OTC: Not Covered.	In-Network: OTC: Not Covered.

PRESCRIPTION DRUG BENEFITS

Benefits/Services	Prominence Plus (HMO)	Prominence Giveback (HMO)	Prominence Beyond (HMO-POS)
Deductible Prescription Drug Deductible:	Prescription Drug Deductible: \$0 deductible	Prescription Drug Deductible: \$0 deductible	Prescription Drug Deductible: \$0 deductible
Initial Coverage You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. You then move on to the Catastrophic Coverage Stage.			
	Standard Retail Cost-Sharing	Standard Retail Cost-Sharing	Standard Retail Cost-Sharing
Tier	One-month supply	One-month supply	One-month supply
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$12 copay	\$11 copay	\$15 copay
Tier 3 (Preferred Brand)	\$45 copay	25% coinsurance	\$47 copay
Tier 4 (Non-Preferred Drug)	\$100 copay	35% coinsurance	\$100 copay
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance
Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay	\$0 copay
	Standard Mail Order	Standard Mail Order	Standard Mail Order
Tier	Three-month supply	Three-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$24 copay	\$33 copay	\$30 copay
Tier 3 (Preferred Brand)	\$135 copay	25% coinsurance	\$141 copay
Tier 4 (Non-Preferred Drug)	\$300 copay	35% coinsurance	\$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance

Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay	\$0 copay
Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug. Please call us or see the plan’s “Evidence of Coverage” on our website (www.prominencemedicare.com) for complete information about your costs for covered drugs.			
Catastrophic Amount During this payment stage, the plan pays the full cost for your covered Part D drugs.			

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-855-969-5882 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-855-969-5882 (TTY: 711).

Prominence Plus (HMO), Prominence Giveback (HMO) and Prominence Beyond (HMO-POS) are HMO plans with a Medicare contract. Enrollment in **Prominence Plus (HMO), Prominence Giveback (HMO) and Prominence Beyond (HMO-POS)** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Prominence Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Prominence Healthfirst of Texas.

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 1-855-969-5882 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.prominencemedicare.com or call 1-855-969-5882 (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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, 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/co-insurance may change on January 1, 2027.
- ☐ 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).

Connect with us

Contact Information: 1-855-969-5882 (TTY:711)

Organization Name: Prominence Health

Organization Website: prominencemedicare.com