2019 SUMMARY *of* BENEFITS

Prominence Plus (HMO)
H7680, Plan 002 (South Texas)

This is a summary of health and drug services covered by Prominence Health Plan for January 1, 2019 through December 31, 2019.

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 *2019 Evidence of Coverage* booklet by calling 1-855-969-5882 (TTY users should call 711). You can also view and download the *2019 Evidence of Coverage* booklet at ProminenceMedicare.com.

Prominence Plus plans have 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 Plus, 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 Texas:

H7680-002 (South Texas): Brooks, Hidalgo, Starr

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, seven days a week. (TTY users call 1-877-486-2048.)

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), 8:00 a.m. to 8:00 p.m. seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. You can also visit us at ProminenceMedicare.com.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Monthly plan premium	You pay $0.	You must continue to pay your Medicare Part B premium.
Monthly premium for optional supplemental comprehensive dental coverage	You pay $22.00 (if you elect the supplemental comprehensive dental coverage).	This premium only applies if you elect the optional supplemental dental coverage.
Deductible	You pay a $50 deductible (if you elect the supplemental dental coverage).	These plans do not have a deductible for medical services.
Maximum out-of-pocket responsibility (Does not include prescription drug costs)	$4,500 annually.	This is the most you pay for copayments, coinsurance and other costs for medical services covered under Medicare Parts A and B for the year.
Inpatient hospital coverage	You pay a $600 copayment per inpatient stay.	Our plans cover an unlimited number of days for an inpatient stay. 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	You pay a $50 copayment for wound care treatment at provider offices, ambulatory surgical center or contracted wound care center.	Prior authorization is required for outpatient and observation services.
	You pay a $200 copayment for outpatient hospital services.	
	You pay a $250 copayment for all services received during observation care.	
Doctor visits • Primary care providers • Specialists	You pay $0 per primary care visit.	There are no referrals required for specialist visits.
	You pay a $35 copayment per specialist visit.	

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Preventive care	You pay $0 for Original Medicare preventive services that are offered at $0 cost-sharing (see list below). There are other covered preventive services that have a copayment.	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 *2019 Evidence of Coverage*.

Medicare-covered preventive services with no copayment:

- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammograms)
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (flexible sigmoidoscopy, fecal occult blood test, fecal immunochemical test)
- Depression screening
- Diabetes screening
- HIV screening
- Immunizations (pneumonia, influenza, and Hepatitis B vaccines)
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and therapy to promote sustained weight loss
- Prostate cancer screening exams for men aged 50 and older
- Screening and counseling to reduce alcohol misuse
- Screening for lung cancer with low-dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- “Welcome to Medicare” Preventive Visit

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Emergency care	You pay a $90 copayment per visit.	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.
Urgently needed services	You pay a $25 copayment per visit.	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.
Diagnostic services/ Labs/Imaging • Diagnostic procedures/ tests and lab services • Diagnostic radiological services (such as CT scans, MRIs) • Therapeutic radiological services • Outpatient x-rays	You pay $0 for diagnostic procedures/tests and lab services. You pay a $225 copayment for diagnostic radiological services, such as CT scans and MRIs. You pay a $60 copayment for therapeutic radiological services. You pay a $15 copayment for x-ray services.	If you receive multiple services at the same location on the same day, only one copayment applies. Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.
Hearing services	You pay $0 for a routine hearing exam. One exam is covered annually. You pay 0% of the total cost for Medicare-covered hearing services. Hearing aid benefit: You pay 44 – 66% of the total cost, dependent upon the technology level of the hearing aids selected.	Annual maximum coverage-amount of $500 for hearing aids (per ear) applies. Prior authorization and referrals are not required.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Dental services (Medicare-covered)	You pay a $35 copayment for Medicare-covered dental services.	Prior authorization and referrals are not required.
Dental services (preventive)	Preventive dental services are included with no additional monthly premium. Covered services include: • teeth cleaning, once every six months • oral exam, once every six months • dental x-rays, once a year	There is no deductible, copayment, or coinsurance for preventive dental services. Prior authorization and referrals are not required
Dental services (optional comprehensive)	You may elect optional supplemental dental coverage (monthly premium applies). Covered optional supplemental services may include: • restorative services • endodontics • periodontics • extractions • prosthodontics • other oral/maxillofacial surgery • other services. You pay a $50 deductible for non-Medicare Part A and Part B dental services. You pay 30-50% of the total cost of the covered service (depending on service).	$1,000 per year maximum coverage amount for non-Medicare Part A and Part B dental services. Prior authorization and referrals are not required. Please call the Plan for more information.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Vision services	You pay a $35 copayment for Medicare-covered eye exams, including an annual glaucoma screening.	After cataract surgery, Medicare helps pay for one pair of corrective lenses/glasses or one set of contact lenses. You are responsible for 20% coinsurance for the corrective lenses and any additional costs for upgrades. You are responsible for 100% of any non-covered service. Prior authorization and referrals are not required.
	You pay a $25 copayment for routine eye exams. One exam is covered annually.	
	You pay 20% of the total cost for eyeglasses or contact lenses after each cataract surgery.	
	You receive a $200 annual allowance for eye wear (eyeglasses (lenses and frames) or contact lenses).	
Mental health services • Inpatient visits • Outpatient therapy visits • Partial hospitalization	You pay a $330 copayment per day, days 1 through 5; $0 copayment per day, days 6 through 90 for inpatient mental health stays. For use of Medicare-covered lifetime reserve days (used if an inpatient stay for mental health services lasts longer than 90 days per benefit period), you pay a $330 copayment per day, for days 1 through 5; $0 copayment per day, days 6 through 60.	For inpatient mental health care stays, your physician is required to notify the plan when you are admitted. 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. Prior authorization is required for partial hospitalization services.
	You pay a $35 copayment for individual or group mental health sessions	
	You pay a $55 copayment per day for partial hospitalization services.	

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Skilled nursing facility	You pay a $0 copayment per day, days 1 – 20; $170 copayment per day, days 21 – 45; and $0 copayment per day, days 46 – 100.	Prior authorization is required.
Physical therapy	You pay a $40 copayment per visit.	Prior authorization is required.
Ambulance	You pay a $225 copayment per transportation segment.	Copayment applies per segment. A segment is transport by ambulance to the nearest appropriate facility. Another segment is incurred if the beneficiary is then transported by ambulance to another facility. Prior authorization is required for non-emergency transport. The copayment is waived if you are admitted to the hospital.
Transportation	You pay $0 for plan-approved transportation services.	Members of Prominence Plus (HMO) plan H7680-002 (South TX) can access 20 one-way trips to plan-approved locations. Transportation may include rides by taxi, bus/subway, van, or medical transport.
Medicare Part B drugs	You pay 20% of the total cost of chemotherapy and other Part B drugs.	Prior authorization is required for all Part B drugs with a cost greater than $100.
Annual physical exam	You pay $0 for the annual physical exam.	You pay the plan cost-sharing amount for screening exams and/or diagnostic tests received in preparation for this visit or ordered as a result of this visit.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Ambulatory surgical center services	You pay a $150 copayment for services received at an ambulatory surgical center.	Prior authorization is required.
Medical equipment/ supplies • Durable medical equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) and medical supplies • Diabetic supplies	You pay 20% of the total cost of durable medical equipment.	Prior authorization is required for items with a purchase price greater than $500 or $38.50 per month, if rented.
	You pay 20% of the total cost of prosthetic devices. You pay 10% of the total cost of medical supplies.	Prior authorization is required for devices/ supplies with a purchase price greater than $500 or $38.50 per month, if rented.
	You pay 10% of the total cost of diabetic supplies. You pay 20% of the total cost of diabetic therapeutic shoes or inserts.	The only covered blood glucose monitors and test strips are CONTOUR® products manufactured by Ascensia Diabetes Care. Alternate brand products are not covered unless a request for prior authorization is approved.
Podiatry services (foot care)	You pay a $50 copayment for Medicare-covered podiatry services.	Routine foot care is not covered.
Acupuncture	Not covered.	
Chiropractic care • Manipulation of the spine to correct subluxation	You pay a $20 copayment for Medicare-covered chiropractic services.	Prior authorization is required for all visits over 10 annually.
Fitness benefit (fitness center membership)	You pay $0.	A no-cost fitness center membership to a participating fitness center or up to two home fitness kits through the Silver&Fit® Exercise and Healthy Aging Program.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Over-the-counter (OTC) medications and products	You receive a $50 allowance, every three months for OTC items.	Unused balances do not carry over to the next period if unused. For more information on OTC products, please call Member Services or visit our website.
Emergency and urgent care (worldwide)	You pay a $90 copayment for an emergency services visit outside the United States. You pay a $25 copayment for an urgent care visit outside the United States.	The copayment will be waived for the emergency services or urgent care visit if you are admitted to the hospital.

IN-NETWORK RETAIL PHARMACY OUTPATIENT PRESCRIPTION DRUGS	
	Prominence Plus (HMO) South TX - 002
Retail Pharmacy 30-day Supply*	
Yearly deductible stage	$300 (The deductible does not apply to drugs in Tiers 1, 2 and 6)
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 a $3 copayment You pay a $12 copayment You pay a $47 copayment You pay a $100 copayment You pay 27% of the total cost You pay $0
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached $3,820).	For drugs in Tiers 1–5, you pay: • 25% of the total cost of brand-name drugs • 37% of the total cost of generic drugs. For Tier 6 drugs, you pay $0.
Catastrophic coverage stage (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach $5,100)	For drugs in Tiers 1–5, you pay: • $3.40 copayment (for generic drugs, and drugs that are treated like a generic) **or** • $8.50 copayment (all other drugs) **or** • 5% coinsurance (whichever is larger). For Tier 6 drugs, you pay $0.

MAIL ORDER OUTPATIENT PRESCRIPTION DRUGS	
	Prominence Plus (HMO) South TX - 002
Mail Order 100-day Supply	
Yearly deductible stage	$300 (The deductible does not apply to drugs in Tiers 1, 2 and 6)
Initial coverage stage	
Tier 1: Preferred Generic	You pay a $6 copayment
Tier 2: Generic	You pay a $24 copayment
Tier 3: Preferred Brand	You pay a $141 copayment
Tier 4: Non-preferred Drugs	You pay a $300 copayment
Tier 5: Specialty Drugs	Not Available
Tier 6: Select Care Drugs	You pay $0
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached $3,820).	For drugs in Tiers 1–5, you pay: • 25% of the total cost of brand-name drugs • 37% of the total cost of generic drugs. For Tier 6 drugs, you pay $0.
Catastrophic coverage stage (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach $5,100)	For drugs in Tiers 1–5, you pay: • $3.40 copayment (for generic drugs, and drugs that are treated like a generic) **or** • $8.50 copayment (all other drugs) **or** • 5% coinsurance (whichever is larger). For Tier 6 drugs, 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 *2019 Evidence of Coverage* online at ProminenceMedicare.com.

*Prescription drugs may be up to a 100-day supply

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. – 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.

The Silver & Fit® program is provided by American Specialty Health Fitness, Incorporated (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas.

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

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-969-5882 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-969-5882 (TTY/TDD: 711).

Prominence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Prominence Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Sumusunod ang Prominence Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Prominence Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.