



2019 SUMMARY OF BENEFITS

Benefits effective January 1, 2019

**Prominence Plus
Medicare Advantage HMO Plan**

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

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. – 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 nandiskrimina 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.

2019 SUMMARY *of* BENEFITS

Prominence Plus (HMO)

H5945, Plans 001 (Northern Nevada) and 002 (Washoe)

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 (HMO) 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 (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:

H5945-001 (Northern Nevada): Carson City, Douglas, Lyon, Storey

H5945-002 (Washoe): Washoe

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.

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.

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
Monthly plan premium	You pay \$0.	You pay \$0.	You must continue to pay your Medicare Part B premium.
Monthly premium for optional supplemental preventive and comprehensive dental coverage	You pay \$29.00 (if you elect the supplemental preventive and comprehensive dental coverage).	You pay \$29.00 (if you elect the supplemental preventive and 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).	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)	\$4,900 annually.	\$4,900 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 \$335 copayment per day for days 1 through 5; \$0 copayment per day for days 6 through 90.	You pay a \$335 copayment per day for days 1 through 5; \$0 copayment per day for days 6 through 90.	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 <ul style="list-style-type: none">Outpatient surgery or other services received in an outpatient hospital setting	You pay a \$50 copayment for wound care treatment at provider offices, ambulatory surgical center or contracted wound care center.	You pay a \$50 copayment for wound care treatment at provider offices, ambulatory surgical center or contracted wound care center.	Authorization is required for outpatient and observation services.
You pay a \$375 copayment for outpatient hospital services.	You pay a \$375 copayment for outpatient hospital services.		

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
<ul style="list-style-type: none"> Observation care 	You pay a \$350 copayment for all services received during observation care.	You pay a \$350 copayment for all services received during observation care.	
Doctor visits <ul style="list-style-type: none"> Primary care providers Specialists 	You pay \$0 per primary care visit.	You pay \$0 per primary care visit.	There are no referrals required for specialist visits.
	You pay a \$50 copayment per specialist visit.	You pay a \$50 copayment per specialist visit.	
Preventive care	<p>You pay \$0 for Original Medicare preventive services that are offered at \$0 cost-sharing (see list below).</p> <p>There are other covered preventive services that have a copayment.</p>	<p>You pay \$0 for Original Medicare preventive services that are offered at \$0 cost-sharing (see list below).</p> <p>There are other covered preventive services that have a copayment.</p>	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>For more information, please see Chapter 4: “Medical Benefits Chart (what is covered and what you pay)” in the <i>2019 Evidence of Coverage</i>.</p>

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

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
<ul style="list-style-type: none"> • 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 			
Emergency care	You pay a \$90 copayment per visit.	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 \$35 copayment per visit.	You pay a \$35 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 <ul style="list-style-type: none"> • Diagnostic procedures/ tests and lab services 	You pay \$0 for diagnostic procedures/tests and lab services.	You pay \$0 for diagnostic procedures/tests and lab services.	If you receive multiple services at the same location on the same day, only one copayment applies.

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
<ul style="list-style-type: none"> Diagnostic radiological services (such as CT scans, MRIs) Therapeutic radiological services Outpatient x-rays 	You pay a \$225 copayment for diagnostic radiological services, such as CT scans and MRIs.	You pay a \$225 copayment for diagnostic radiological services, such as CT scans and MRIs.	Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.
	You pay a \$60 copayment for therapeutic radiological services.	You pay a \$60 copayment for therapeutic radiological services.	
	You pay a \$25 copayment for x-ray services.	You pay a \$25 copayment for x-ray services.	
Hearing services	You pay \$0 for a routine hearing exam. One exam is covered annually.	You pay \$0 for a routine hearing exam. One exam is covered annually.	Annual maximum coverage-amount of \$500 for hearing aids (per ear) applies.
	You pay a \$35 copayment for Medicare-covered hearing services.	You pay a \$35 copayment for Medicare-covered hearing services.	Member out-of-pocket per hearing aid varies based on technology level selected.
	Hearing aid benefit: You pay 44 – 66% of the total cost, dependent upon the technology level of the hearing aids selected.	Hearing aid benefit: You pay 44 – 66% of the total cost, dependent upon the technology level of the hearing aids selected.	Prior authorization and referrals are not required.
Dental services (Medicare-covered)	You pay a \$50 copayment for Medicare-covered dental services.	You pay a \$50 copayment for Medicare-covered dental services.	Prior authorization and referrals are not required.
Dental services (optional preventive and comprehensive)	You may elect optional supplemental dental coverage (monthly premium applies).	You may elect optional supplemental dental coverage (monthly premium applies).	\$1,000 per year maximum coverage amount for non-Medicare Part A and Part B dental services.

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
<p>Dental services (optional preventive and comprehensive) continued</p>	<p>Covered optional preventive services may include:</p> <ul style="list-style-type: none"> • teeth cleaning, once every six months • oral exam, once a year • dental x-rays, once a year <p>You pay 20% of the total cost of the visit.</p> <p>Covered optional comprehensive services may include:</p> <ul style="list-style-type: none"> • restorative services • endodontics • periodontics • extractions • prosthodontics • other oral/maxillofacial surgery • other services. <p>You pay a \$50 deductible for non-Medicare Part A and Part B dental services.</p>	<p>Covered optional preventive services may include:</p> <ul style="list-style-type: none"> • teeth cleaning, once every six months • oral exam, once a year • dental x-rays, once a year <p>You pay 20% of the total cost of the visit.</p> <p>Covered optional comprehensive services may include:</p> <ul style="list-style-type: none"> • restorative services • endodontics • periodontics • extractions • prosthodontics • other oral/maxillofacial surgery • other services. <p>You pay a \$50 deductible for non-Medicare Part A and Part B dental services.</p>	<p>Prior authorization and referrals are not required.</p> <p>Please call the Plan for more information.</p>
<p>Vision services</p>	<p>You pay a \$35 copayment for Medicare-covered eye exams, including an annual glaucoma screening.</p> <p>You pay a \$25 copayment for routine eye exams. One exam is covered annually.</p>	<p>You pay a \$35 copayment for Medicare-covered eye exams, including an annual glaucoma screening.</p> <p>You pay a \$25 copayment for routine eye exams. One exam is covered annually.</p>	<p>Prior authorization and referrals are not required.</p> <p>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</p>

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
Vision services continued	You pay 20% of the total cost for eyeglasses or contact lenses after each cataract surgery.	You pay 20% of the total cost for eyeglasses or contact lenses after each cataract surgery.	the corrective lenses and any additional costs for upgrades. You are responsible for 100% of any non-covered service.
	You receive a \$150 annual allowance for eye wear (eyeglasses (lenses and frames) or contact lenses).	You receive a \$150 annual allowance for eye wear (eyeglasses (lenses and frames) or contact lenses).	
Mental health services <ul style="list-style-type: none"> • Inpatient visits • Outpatient therapy visits • Partial hospitalization 	<p>You pay a \$330 copayment per day, days 1 through 5;</p> <p>\$0 copayment per day, days 6 through 90 for inpatient mental health stays.</p> <p>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;</p> <p>\$0 copayment per day, days 6 through 60.</p>	<p>You pay a \$330 copayment per day, days 1 through 5;</p> <p>\$0 copayment per day, days 6 through 90 for inpatient mental health stays.</p> <p>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;</p> <p>\$0 copayment per day, days 6 through 60.</p>	<p>For inpatient mental health care stays, your physician is required to notify the plan when you are admitted.</p> <p>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.</p> <p>Prior authorization is required for partial hospitalization services.</p>
	You pay a \$40 copayment for individual or group mental health sessions.	You pay a \$40 copayment for individual or group mental health sessions	
	You pay a \$55 copayment per day for partial hospitalization services.	You pay a \$55 copayment per day for partial hospitalization services.	

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
Skilled nursing facility	You pay a \$0 copayment per day, days 1 – 20; \$170 copayment per day, days 21 – 100.	You pay a \$0 copayment per day, days 1 – 20; \$170 copayment per day, days 21 – 100.	Prior authorization is required.
Physical therapy	You pay a \$40 copayment per visit.	You pay a \$40 copayment per visit.	Prior authorization is required.
Ambulance	You pay a \$300 copayment per transportation segment.	You pay a \$300 copayment per transportation segment.	<p>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.</p> <p>Prior authorization is required for non-emergency transport.</p> <p>The copayment is waived if you are admitted to the hospital.</p>
Transportation	Not covered.	Not covered.	
Medicare Part B drugs	You pay 20% of the total cost of chemotherapy and other 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.

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
Annual physical exam	You pay \$0 for the 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.
Ambulatory surgical center services	You pay a \$300 copayment for services received at an ambulatory surgical center.	You pay a \$300 copayment for services received at an ambulatory surgical center.	Prior authorization is required.
Medical equipment/ supplies <ul style="list-style-type: none"> • 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.	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 and medical supplies.	You pay 20% of the total cost of prosthetic devices and medical supplies.	Prior authorization is required for devices/ supplies with a purchase price greater than \$500 or \$38.50 per month, if rented.
	<p>You pay 0% of the total cost of diabetic supplies, including meters and test strips.</p> <p>You pay 20% of the total cost of diabetic therapeutic shoes or inserts.</p>	<p>You pay 0% of the total cost of diabetic supplies, including meters and test strips.</p> <p>You pay 20% of the total cost of diabetic therapeutic shoes or inserts.</p>	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.	You pay a \$50 copayment for Medicare-covered podiatry services.	Routine foot care is not covered.

Premiums and benefits	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002	What you should know
Acupuncture	You pay a \$20 copayment per visit.	You pay a \$20 copayment per visit.	Prior authorization is required for all visits over 12 annually.
Chiropractic care <ul style="list-style-type: none"> • Manipulation of the spine to correct subluxation 	You pay a \$20 copayment for Medicare-covered chiropractic services.	You pay a \$20 copayment for Medicare-covered chiropractic services.	Prior authorization is required for all visits over 12 annually.
Fitness benefit (fitness center membership)	You pay \$0.	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.
Over-the-counter (OTC) medications and products	You receive a \$25 allowance a month for OTC items.	You receive a \$25 allowance a month for OTC items.	<p>Unused balances do not carry over to the next period if unused.</p> <p>For more information on OTC products, please call Member Services or visit our website.</p>
Emergency and urgent care (worldwide)	<p>You pay a \$90 copayment for an emergency services visit outside the United States.</p> <p>You pay a \$35 copayment for an urgent care visit outside the United States.</p>	<p>You pay a \$90 copayment for an emergency services visit outside the United States.</p> <p>You pay a \$35 copayment for an urgent care visit outside the United States.</p>	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) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002
Retail Pharmacy 30-day Supply*		
Yearly deductible stage	No deductible.	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 a \$6 copayment You pay a \$16 copayment You pay a \$47 copayment You pay a \$100 copayment You pay 33% of the total cost You pay \$0	You pay a \$6 copayment You pay a \$16 copayment You pay a \$47 copayment You pay a \$100 copayment You pay 33% 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: <ul style="list-style-type: none"> • 25% of the total cost of brand-name drugs • 37% of the total cost of generic drugs. For Tier 6 drugs, you pay \$0.	For drugs in Tiers 1–5, you pay: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • \$3.40 copayment (for generic drugs, or drugs that are treated like a generic) or • \$8.50 copayment (all other drugs) or • 5% coinsurance (whichever is larger). 	For drugs in Tiers 1–5, you pay: <ul style="list-style-type: none"> • \$3.40 copayment (for generic drugs, or drugs that are treated like a generic) or • \$8.50 copayment (all other drugs) or • 5% coinsurance (whichever is larger).

MAIL ORDER OUTPATIENT PRESCRIPTION DRUGS

	Prominence Plus (HMO) Northern NV - 001	Prominence Plus (HMO) Washoe NV - 002
Mail Order 100-day Supply		
Yearly deductible stage	No deductible.	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 a \$12 copayment You pay a \$32 copayment You pay a \$141 copayment You pay a \$300 copayment Not available You pay \$0	You pay a \$12 copayment You pay a \$32 copayment You pay a \$141 copayment You pay a \$300 copayment Not available 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: <ul style="list-style-type: none"> • 25% of the total cost of brand-name drugs • 37% of the total cost of generic drugs. For Tier 6 drugs, you pay \$0.	For drugs in Tiers 1–5, you pay: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • \$3.40 copayment (for generic drugs, or drugs that are treated like a generic) or • \$8.50 copayment (all other drugs) or • 5% coinsurance (whichever is larger). 	For drugs in Tiers 1–5, you pay: <ul style="list-style-type: none"> • \$3.40 copayment (for generic drugs, or drugs that are treated like a generic) or • \$8.50 copayment (all other drugs) or • 5% coinsurance (whichever is larger).

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

To learn more about our plan or to enroll, call

**TOLL FREE:
833-388-4747**

**TTY:
711**

HOURS:

October 1 to March 31
7 days a week, 8 am – 8 pm

April 1 to September 30
Monday through Friday
8 am – 8 pm


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