

# 2020 SUMMARY *of* BENEFITS

Benefits effective January 1, 2020

Prominence Plus  
Medicare Advantage HMO

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

# 2020 SUMMARY *of* BENEFITS

## **Prominence Plus (HMO)**

### **H5945, Plans 001 (Carson City, Douglas, Lyon, Storey) and 002 (Washoe)**

This is a summary of health and drug services covered by Prominence Health Plan for January 1, 2020 through December 31, 2020.

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 *2020 Evidence of Coverage* booklet by calling 1-855-969-5882 (TTY users should call 711). You can also view and download the *2020 Evidence of Coverage* booklet at [ProminenceMedicare.com](http://ProminenceMedicare.com).

Prominence Plus (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, HMO-POS 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:** Carson City, Douglas, Lyon, Storey

**H5945-002:** Washoe

For coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. You can view it online at [www.medicare.gov](http://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 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) 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](http://ProminenceMedicare.com).

Premiums and benefits	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County	What you should know
<b>Monthly plan premium</b>	You pay \$0.	You pay \$0.	You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	You pay nothing.	You pay nothing.	These plans do not have a deductible.
<b>Maximum out-of-pocket responsibility</b> (Does not include prescription drug costs)	\$3,400 annually.	\$2,900 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.
<b>Inpatient hospital coverage</b>	You pay a \$340 copayment per day for days 1 through 5; \$0 copayment per day for days 6 through 90.	You pay a \$340 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.
<b>Outpatient hospital coverage</b> <ul style="list-style-type: none"> <li data-bbox="110 1354 479 1501">• Outpatient surgery or other services received in an outpatient hospital setting</li> <li data-bbox="110 1627 397 1669">• Observation care</li> </ul>	You pay a \$375 copayment for outpatient hospital services.	You pay a \$375 copayment for outpatient hospital services.	Prior authorization is required for outpatient and observation services.
You pay a \$350 copayment for all services received during observation care.	You pay a \$350 copayment for all services received during observation care.		

Premiums and benefits	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County	What you should know
	You pay a \$30 copayment for wound care treatment at provider offices, ambulatory surgical center or contracted wound care center.	You pay a \$30 copayment for wound care treatment at provider offices, ambulatory surgical center or contracted wound care center.	
<b>Doctor visits</b> <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Specialists</li> </ul>	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 \$30 copayment per specialist visit.	You pay a \$30 copayment per specialist visit.	
<b>Preventive care</b>	You pay \$0 for Original Medicare preventive services.	You pay \$0 for Original Medicare preventive services.	<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>2020 Evidence of Coverage</i>.</p>
<b>Emergency care</b>	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.

Premiums and benefits	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County	What you should know
<b>Urgently needed services</b>	You pay a \$30 copayment per visit.	You pay a \$30 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.
<b>Diagnostic services/ Labs/Imaging</b> <ul style="list-style-type: none"> <li data-bbox="110 758 475 827">• Diagnostic procedures/ tests and lab services</li> <li data-bbox="110 961 467 1073">• Diagnostic radiological services (such as CT scans, MRIs)</li> <li data-bbox="110 1150 435 1220">• Therapeutic radiological services</li> <li data-bbox="110 1297 391 1331">• Outpatient x-rays</li> </ul>	You pay \$0 for diagnostic procedures/tests and lab services.	You pay \$0 for diagnostic procedures/tests and lab services.	<p data-bbox="1235 659 1552 842">If you receive multiple services at the same location on the same day, only one copayment applies.</p> <p data-bbox="1235 915 1560 1129">Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.</p>
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.		
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.		
<b>Hearing services</b>	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.	<p data-bbox="1235 1444 1544 1591">Annual maximum coverage-amount of \$500 for hearing aids (per ear) applies.</p> <p data-bbox="1235 1629 1552 1776">Member out-of-pocket per hearing aid varies based on technology level selected.</p>

Premiums and benefits	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County	What you should know
<b>Hearing services (continued)</b>	You pay a \$30 copayment for Medicare-covered hearing services.	You pay a \$30 copayment for Medicare-covered hearing services.	Members will receive a negotiated plan discount on hearing aids if they purchase hearing aids from our preferred vendor, Hearing Care Solutions.  Prior authorization and referrals are not required.
<b>Dental services (Medicare-covered)</b>	You pay a \$0 copayment for Medicare-covered dental services.	You pay a \$0 copayment for Medicare-covered dental services.	Prior authorization and referrals are not required.
<b>Dental services (preventive)</b>	Preventive dental services are included with no additional monthly premium.  Covered preventive services include: <ul style="list-style-type: none"> <li>• teeth cleaning, once every six months</li> <li>• oral exam, once a year</li> <li>• dental x-rays, once a year</li> </ul>	Preventive dental services are included with no additional monthly premium.  Covered preventive services include: <ul style="list-style-type: none"> <li>• teeth cleaning, once every six months</li> <li>• oral exam, once a year</li> <li>• dental x-rays, once a year</li> </ul>	There is no deductible, copayment, or coinsurance for preventive dental services.  \$500 per year maximum coverage amount for preventive dental services.  Prior authorization and referrals are not required.

Premiums and benefits	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County	What you should know
<b>Dental services (comprehensive)</b>	<p>Comprehensive dental services are included with no additional monthly premium.</p> <p>Covered comprehensive services include:</p> <ul style="list-style-type: none"> <li>• non-routine services</li> <li>• diagnostic services</li> <li>• restorative services</li> <li>• endodontics</li> <li>• periodontics</li> <li>• extractions</li> <li>• prosthodontics</li> <li>• other oral/maxillofacial surgery.</li> </ul>	<p>Comprehensive dental services are included with no additional monthly premium.</p> <p>Covered comprehensive services include:</p> <ul style="list-style-type: none"> <li>• non-routine services</li> <li>• diagnostic services</li> <li>• restorative services</li> <li>• endodontics</li> <li>• periodontics</li> <li>• extractions</li> <li>• prosthodontics</li> <li>• other oral/maxillofacial surgery.</li> </ul>	<p>There is no deductible, copayment, or coinsurance for comprehensive dental services.</p> <p>\$1,500 per year maximum coverage amount for comprehensive dental services.</p> <p>Prior authorization and referrals are not required.</p>
<b>Vision services</b>	<p>You pay a \$30 copayment for Medicare-covered eye exams.</p> <p>You pay a \$20 copayment for routine eye exams. One exam is covered annually.</p> <p>You receive a \$150 annual allowance for eyewear (eyeglasses (lenses and frames) or contact lenses).</p>	<p>You pay a \$30 copayment for Medicare-covered eye exams.</p> <p>You pay a \$20 copayment for routine eye exams. One exam is covered annually.</p> <p>You receive a \$150 annual allowance for eyewear (eyeglasses (lenses and frames) or contact lenses).</p>	<p>Prior authorization and referrals are not required.</p>



<b>Premiums and benefits</b>	<b>Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties</b>	<b>Prominence Plus (HMO) – 002 Washoe County</b>	<b>What you should know</b>
<b>Physical therapy</b>	You pay a \$40 copayment per visit.	You pay a \$40 copayment per visit.	Prior authorization is required for all visits over 12 annually.
<b>Ambulance</b>	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>
<b>Transportation</b>	You pay \$0 for plan-approved transportation services.	You pay \$0 for plan-approved transportation services.	<p>Members can access up to five (5) one-way trips to plan-approved health-related locations.</p> <p>Transportation may include rides by taxi, bus/subway, van, or medical transport.</p> <p>You must call Member Services to arrange transportation.</p>
<b>Medicare Part B drugs</b>	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.

<b>Premiums and benefits</b>	<b>Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties</b>	<b>Prominence Plus (HMO) – 002 Washoe County</b>	<b>What you should know</b>
<b>Annual physical exam</b>	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.
<b>Ambulatory surgical center services</b>	You pay a \$200 copayment for services received at an ambulatory surgical center.	You pay a \$200 copayment for services received at an ambulatory surgical center.	Prior authorization is required.
<b>Medical equipment/ supplies</b> <ul style="list-style-type: none"> <li data-bbox="110 976 446 1081">• Durable medical equipment (e.g., wheelchairs, oxygen)</li> <li data-bbox="110 1165 462 1270">• Prosthetics (e.g., braces, artificial limbs) and medical supplies</li> <li data-bbox="110 1396 389 1428">• Diabetic supplies</li> </ul>	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.
	You pay 0% of the total cost of diabetic supplies, including meters and test strips.  You pay 20% of the total cost of diabetic therapeutic shoes or inserts.	You pay 0% of the total cost of diabetic supplies, including meters and test strips.  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.

Premiums and benefits	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County	What you should know
<b>Podiatry services (foot care)</b>	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.
<b>Acupuncture</b>	You pay a \$20 copayment per visit.	You pay a \$20 copayment per visit.	Prior authorization is required for all visits over 12 annually.
<b>Chiropractic care</b> <ul style="list-style-type: none"> <li>• Manipulation of the spine to correct subluxation</li> </ul>	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.
<b>Fitness benefit (fitness center membership)</b>	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® Program.
<b>Over-the-counter (OTC) medications and products</b>	You receive a \$100 allowance every three months for OTC items.	You receive a \$100 allowance every three months for OTC items.	Unused balances do not carry over to the next period.

<b>Premiums and benefits</b>	<b>Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties</b>	<b>Prominence Plus (HMO) – 002 Washoe County</b>	<b>What you should know</b>
<b>Emergency and urgent care (worldwide)</b>	<p>You pay a \$90 copayment for an emergency services visit outside the United States.</p> <p>You pay a \$30 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 \$30 copayment for an urgent care visit outside the United States.</p>	<p>The copayment will be waived for the emergency services or urgent care visit if you are admitted to the hospital.</p>

## IN-NETWORK RETAIL PHARMACY OUTPATIENT PRESCRIPTION DRUGS

	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County
Retail Pharmacy 30-day Supply*		
<b>Yearly deductible stage</b>	No deductible.	No deductible.
<b>Initial coverage stage</b> 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 \$0 copayment You pay a \$16 copayment You pay a \$40 copayment You pay a \$100 copayment You pay 33% of the total cost You pay \$0	You pay a \$0 copayment You pay a \$16 copayment You pay a \$40 copayment You pay a \$100 copayment You pay 33% of the total cost You pay \$0
<b>Coverage gap stage</b> (You enter the coverage gap stage when your total drug costs have reached \$4,020).	For drugs in Tiers 3, 4 and 5, you pay: <ul style="list-style-type: none"> <li>• 25% of the total cost of brand-name drugs</li> <li>• 25% of the total cost of generic drugs.</li> </ul> Tier 1, 2 and 6 drugs are covered in the gap.	For drugs in Tiers 3, 4 and 5, you pay: <ul style="list-style-type: none"> <li>• 25% of the total cost of brand-name drugs</li> <li>• 25% of the total cost of generic drugs.</li> </ul> Tier 1, 2 and 6 drugs are covered in the gap.
<b>Catastrophic coverage stage</b> (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach \$6,350).	For drugs in Tiers 2, 3, 4 and 5, you pay: <ul style="list-style-type: none"> <li>• \$3.60 copayment (for generic drugs, or drugs that are treated like a generic) <b>or</b></li> <li>• \$8.95 copayment (all other drugs) <b>or</b></li> <li>• 5% coinsurance (whichever is larger).</li> </ul> For Tier 1 and 6 drugs, you pay \$0.	For drugs in Tiers 2, 3, 4 and 5, you pay: <ul style="list-style-type: none"> <li>• \$3.60 copayment (for generic drugs, or drugs that are treated like a generic) <b>or</b></li> <li>• \$8.95 copayment (all other drugs) <b>or</b></li> <li>• 5% coinsurance (whichever is larger).</li> </ul> For Tier 1 and 6 drugs, you pay \$0.

## MAIL ORDER OUTPATIENT PRESCRIPTION DRUGS

	Prominence Plus (HMO) – 001 Carson City, Douglas, Lyon, Storey Counties	Prominence Plus (HMO) – 002 Washoe County
Mail Order 100-day Supply		
<b>Yearly deductible stage</b>	No deductible.	No deductible.
<b>Initial coverage stage</b>  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 \$0 copayment You pay a \$32 copayment You pay a \$120 copayment You pay a \$300 copayment Not available You pay \$0	You pay a \$0 copayment You pay a \$32 copayment You pay a \$120 copayment You pay a \$300 copayment Not available You pay \$0
<b>Coverage gap stage</b> (You enter the coverage gap stage when your total drug costs have reached \$4,020).	For drugs in Tiers 3, 4 and 5, you pay:  <ul style="list-style-type: none"> <li>• 25% of the total cost of brand-name drugs</li> <li>• 25% of the total cost of generic drugs.</li> </ul> Tier 1, 2 and 6 drugs are covered in the gap.	For drugs in Tiers 3, 4 and 5, you pay:  <ul style="list-style-type: none"> <li>• 25% of the total cost of brand-name drugs</li> <li>• 25% of the total cost of generic drugs.</li> </ul> Tier 1, 2 and 6 drugs are covered in the gap.
<b>Catastrophic coverage stage</b> (You enter the catastrophic coverage stage when your out-of-pocket drug costs reach \$6,350).	For drugs in Tiers 2, 3, 4 and 5, you pay:  <ul style="list-style-type: none"> <li>• \$3.60 copayment (for generic drugs, or drugs that are treated like a generic) <b>or</b></li> <li>• \$8.95 copayment (all other drugs) <b>or</b></li> <li>• 5% coinsurance (whichever is larger).</li> </ul> For Tier 1 and 6 drugs, you pay \$0.	For drugs in Tiers 2, 3, 4 and 5, you pay:  <ul style="list-style-type: none"> <li>• \$3.60 copayment (for generic drugs, or drugs that are treated like a generic) <b>or</b></li> <li>• \$8.95 copayment (all other drugs) <b>or</b></li> <li>• 5% coinsurance (whichever is larger).</li> </ul> For Tier 1 and 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 *2020 Evidence of Coverage* online at [ProminenceMedicare.com](http://ProminenceMedicare.com).

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

## 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](http://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 medicines 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/co-insurance may change on January 1, 2021.
- 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).

Prominence Health Plan is an HMO, HMO-POS 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](http://ProminenceMedicare.com).

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

The Silver & Fit<sup>®</sup> 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: 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: 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.