2020 SUMMARY *of* BENEFITS

Benefits effective January 1, 2020

Prominence Plus
Medicare Advantage HMO-POS

North Texas Region
Cooke, Deaf Smith, Fannin, Gray, Grayson,
Moore, Potter and Randall Counties

Y0109_NTXSB20_M_CMS Accepted

2020 SUMMARY *of* BENEFITS

Prominence Plus (HMO-POS)
H7680, Plan 001 (North Texas)

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.

Prominence Plus (HMO-POS) 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 those services.

With the Point-of-Service (POS) option, for some services you may use providers that are not in our network and pay a higher cost.

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-POS), 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:

H7680-001 (North Texas): Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter, Randall

For coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. You can view it online at www.medicare.gov or request a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 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-POS) North TX - 001	What you should know
Monthly plan premium	You pay $0.	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing.	This plan does not have a deductible.
Maximum out-of-pocket responsibility (Does not include prescription drug costs)	$4,600 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 $280 copayment per day for days 1 through 5; $0 copayment per day for days 6 through 90.	Our plan covers 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	You pay a $325 copayment for outpatient hospital services.	Prior authorization is required for outpatient and observation services.
• Observation care	You pay a $275 copayment for all services received during observation care.	
	You pay a $50 copayment for wound care treatment at provider offices, ambulatory surgical center or contracted wound care center.	
Doctor visits • Primary care providers	You pay $0 per primary care visit.	There are no referrals required for specialist visits.
• Specialists	You pay a $30 copayment per specialist visit. Out-of-network: 40% coinsurance.	

Premiums and benefits	Prominence Plus (HMO-POS) North TX - 001	What you should know
Preventive care	You pay $0 for Original Medicare preventive services.	Any additional preventive services approved by Medicare during the contract year will be covered. For more information, please see Chapter 4: "Medical Benefits Chart (what is covered and what you pay)" in the *2020 Evidence of Coverage*.
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 $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 • 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. Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.
• Diagnostic radiological services (such as CT scans, MRIs)	You pay a $200 copayment for diagnostic radiological services, such as CT scans and MRIs.	
• Therapeutic radiological services	You pay a $60 copayment for therapeutic radiological services.	
• Outpatient x-rays	You pay a $55 copayment for x-ray services.	
Hearing services	You pay $0 for a routine hearing exam. One exam is covered annually.	Annual maximum coverage-amount of $700 for hearing aids (per ear) applies.

Premiums and benefits	Prominence Plus (HMO-POS) North TX - 001	What you should know
Hearing services (continued)	You pay a $30 copayment for Medicare-covered hearing services.	Prior authorization and referrals are not required. Member out-of-pocket per hearing aid varies based on technology level selected. Members will receive a negotiated plan discount on hearing aids if they purchase hearing aids from our preferred vendor, Hearing Care Solutions.
Dental services (Medicare-covered)	You pay a $0 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 preventive services include: • teeth cleaning, once every six months • oral exam, once a year • dental x-rays, once a year	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-POS) North TX - 001	What you should know
Dental services (comprehensive)	Comprehensive dental services are included with no additional monthly premium. Covered comprehensive services include: • non-routine services • diagnostic services • restorative services • endodontics • periodontics • extractions • prosthodontics • other oral/maxillofacial surgery.	There is no deductible, copayment, or coinsurance for comprehensive dental services. $1,000 per year maximum coverage amount for comprehensive dental services. Prior authorization and referrals are not required.
Vision services	You pay a $30 copayment for Medicare-covered eye exams.	Prior authorization and referrals are not required.
	You pay a $0 copayment for routine eye exams. One exam is covered annually.	
	You receive a $150 annual allowance for eyewear (eyeglasses (lenses and frames) or contact lenses).	

Premiums and benefits	Prominence Plus (HMO-POS) North TX - 001	What you should know
Mental health services • Inpatient visits	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.
• Outpatient therapy visits	You pay a $30 copayment for individual or group mental health sessions.	
• Partial hospitalization	You pay a $55 copayment per day for partial hospitalization services.	
Skilled nursing facility	You pay a $0 copayment per day, days 1 – 20; $160 copayment per day, days 21 – 45; and $0 copayment per day, days 46 – 100.	Prior authorization is required.
Physical therapy	You pay a $20 copayment per visit. Out-of-network: 40% coinsurance.	Prior authorization is required for all visits over 12 annually.

Premiums and benefits	Prominence Plus (HMO-POS) North TX - 001	What you should know
Ambulance	You pay a $310 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 can access up to eight (8) one way trips to plan-approved health-related locations. Transportation may include rides by taxi, bus/subway, van, or medical transport. You must call Member Services to arrange transportation.
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.
Ambulatory surgical center services	You pay a $250 copayment for services received at an ambulatory surgical center.	Prior authorization is required.

Premiums and benefits	Prominence Plus (HMO-POS) North TX - 001	What you should know
Medical equipment/ supplies • Durable medical equipment (e.g., wheelchairs, oxygen)	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.
• Prosthetics (e.g., braces, artificial limbs) 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.
• Diabetic supplies	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.
Podiatry services (foot care)	You pay a $20 copayment for Medicare-covered podiatry services. Out-of-network: 40% coinsurance.	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 12 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® Program.
Over-the-counter (OTC) medications and products	You receive a $25 allowance, every month for OTC items.	Unused balances do carry over to the next period.

Premiums and benefits	Prominence Plus (HMO-POS) North TX - 001	What you should know
Emergency and urgent care (worldwide)	You pay a $90 copayment for an emergency services visit outside the United States. You pay a $35 copayment for an urgent care visit outside the United States.	Annual maximum coverage-amount of $25,000 applies. 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-POS) North TX - 001
Retail Pharmacy 30-day Supply*	
Yearly deductible stage	No deductible.
Initial coverage stage Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-preferred Drugs Tier 5: Specialty Drugs Tier 6: Select Care Drugs	 You pay a $0 copayment You pay a $13 copayment You pay a $35 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 $4,020).	For drugs in Tiers 3, 4 and 5, you pay: • 25% of the total cost of brand-name drugs • 25% of the total cost of generic drugs. Tier 1, 2 and 6 drugs are covered in the gap.
Catastrophic coverage stage (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: • $3.60 copayment (for generic drugs, or drugs that are treated like a generic) **or** • $8.95 copayment (all other drugs) **or** • 5% coinsurance (whichever is larger). For Tier 1 and 6 drugs, you pay $0.

MAIL ORDER OUTPATIENT PRESCRIPTION DRUGS	
	Prominence Plus (HMO-POS) North TX - 001
Mail Order 100-day Supply	
Yearly deductible stage	No deductible.
Initial coverage stage Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-preferred Drugs Tier 5: Specialty Drugs Tier 6: Select Care Drugs	 You pay a $0 copayment You pay a $26 copayment You pay a $105 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 $4,020).	For drugs in Tiers 3, 4 and 5, you pay: • 25% of the total cost of brand-name drugs • 25% of the total cost of generic drugs. Tier 1, 2 and 6 drugs are covered in the gap.
Catastrophic coverage stage (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: • $3.60 copayment (for generic drugs, or drugs that are treated like a generic) **or** • $8.95 copayment (all other drugs) **or** • 5% coinsurance (whichever is larger). 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.

*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 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).
- ❑ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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.

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: 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: 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.

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.