

2023 SUMMARY *of* BENEFITS

Benefits effective January 1, 2023

Prominence Health Plan
Prominence Plus (HMO)

South Texas Region
Brooks, Cameron, Hidalgo, Jim Hogg, Starr,
Webb, Willacy and Zapata Counties

2023 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, 2023, through December 31, 2023.

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 *2023 Evidence of Coverage* booklet by calling 1-855-969-5882 (TTY users should call 711). You can also view and download the *2023 Evidence of Coverage* booklet at [ProminenceMedicare.com](https://www.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 those services.

Prominence Health Plan is an HMO and HMO SNP plan with a Medicare contract and a contract with the Medicaid program. 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 Texas:

H7680-002 (South Texas): Brooks, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy and Zapata counties

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](https://www.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.
Deductible	You pay nothing.	This plan does not have a deductible.
Maximum out-of-pocket responsibility (Does not include prescription drug costs)	\$3,400 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	\$0 - \$50 per day for days 1 through 5.* \$0 per day for days 6 through 90. *Copay depends on hospital used. Select hospital services are provided at \$0.	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 • Ambulatory surgical center services	You pay \$0 for outpatient hospital services. You pay \$0 for all services received during observation care. You pay \$0 for services received at an ambulatory surgical center.	Prior authorization is required for outpatient, observation services and ambulatory surgical center services.
Doctor visits • Primary care providers • Specialists	You pay \$0 per primary care visit. You pay \$0 per specialist visit.	There are no referrals required for specialist visits.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Preventive care	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>2023 Evidence of Coverage</i>.</p>
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.
Emergency care	<p>\$60 for a Free-Standing emergency facility only. Services at other emergency facilities are \$125 copay.</p>	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.
	You pay \$125 for emergency services visit outside the United States.	Annual maximum coverage-amount of \$25,000 applies for emergency services and urgent care visits outside the United States.
Urgently needed services	You pay \$0 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.
	You pay \$0 for an urgent care visit outside the United States.	Annual maximum coverage-amount of \$25,000 applies for emergency services and urgent care visits outside the United States.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
<p>Diagnostic services/ Labs/Imaging</p> <ul style="list-style-type: none"> • Diagnostic procedures/ tests and lab services • Diagnostic radiological services (such as CT scans, MRIs) • Therapeutic radiological services • Outpatient x-rays 	<p>You pay \$0 for diagnostic procedures/tests and lab services.</p> <p>You pay \$0 for diagnostic radiological services, such as CT scans and MRIs.</p> <p>You pay \$20 for therapeutic radiological services.</p> <p>You pay \$0 for x-ray services.</p>	<p>Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.</p>
<p>Hearing services</p>	<p>You pay \$0 for a routine hearing exam. (Exams for fitting hearing aids.) One exam is covered annually.</p> <p>You pay \$0 for Medicare- covered hearing services. (Diagnostic hearing and balance exams.)</p>	<p>Annual maximum coverage-amount of \$600 for hearing aids (per ear) applies.</p> <p>You are responsible for any amount over the hearing aid coverage limit.</p> <p>All appointments must be scheduled through Hearing Care Solutions. You can contact them at 866-344- 7756.</p> <p>All hearing aids must be purchased through Hearing Care Solutions.</p> <p>Prior authorization and referrals are not required.</p> <p>Member out of pocket per hearing aid varies based on technology level the member selects.</p>
<p>Dental services - Medicare- covered</p>	<p>You pay \$0 for Medicare- covered dental services.</p>	<p>Prior authorization and referrals are not required.</p>

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Dental services - preventive and comprehensive	<p>Preventive and comprehensive dental services are included with no additional monthly premium.</p> <p>Covered services 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 • non-routine services • diagnostic services • restorative services • endodontics • periodontics • extractions • prosthodontics • other oral/maxillofacial surgery 	<p>There is no deductible, copayment, or coinsurance for preventive dental services.</p> <p>There is a 0 – 50% coinsurance for comprehensive dental.</p> <p>\$2,000 per year maximum coverage amount for preventive and comprehensive dental services.</p> <p>You are responsible for any amount over the dental coverage limit.</p> <p>Prior authorization and referrals are not required.</p>
Vision services	<p>You pay \$0 for Medicare-covered eye exams. (Exams to diagnose and treat diseases and conditions of the eye.)</p> <p>You pay \$0 for a routine eye exam. (Eye refractions for eyeglasses and contact lenses) One exam is covered annually.</p> <p>You receive \$200 annual allowance for eyewear (eyeglasses (lenses and frames) or contact lenses).</p>	<p>Prior authorization and referrals are not required.</p> <p>You must use the National Vision Administrators network of providers.</p>

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Mental health services <ul style="list-style-type: none"> <li data-bbox="110 300 342 331">• Inpatient visits <li data-bbox="110 800 480 831">• Outpatient therapy visits <li data-bbox="110 1079 440 1110">• Partial hospitalization 	<p data-bbox="565 237 1011 758"> You pay \$0 per day, days 1 through 5. \$0 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 \$0 per day, for days 1 through 5. \$0 per day, days 6 through 60. </p> <p data-bbox="565 789 992 863">You pay \$0 for individual or group mental health sessions.</p> <p data-bbox="565 1041 984 1115">You pay \$0 per day for partial hospitalization services.</p>	<p data-bbox="1044 237 1539 380">For inpatient mental health care stays, your physician is required to notify the plan when you are admitted.</p> <p data-bbox="1044 789 1544 1010">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 data-bbox="1044 1041 1511 1115">Prior authorization is required for partial hospitalization services.</p>
Skilled nursing facility	<p data-bbox="565 1190 927 1314"> You pay \$0 per day, days 1 – 20. \$50 per day, days 21 – 100. </p>	<p data-bbox="1044 1190 1471 1222">Prior authorization is required.</p>
Physical therapy	<p data-bbox="565 1350 854 1381">You pay \$0 per visit.</p>	<p data-bbox="1044 1350 1511 1423">Prior authorization is required for visits over 12 annually.</p>
Ambulance	<p data-bbox="565 1457 899 1530">You pay \$300 per transportation segment.</p>	<p data-bbox="1044 1457 1544 1677">Copay applies per segment. segment is transport by ambulance to the nearest appropriate facility. Another segment is incurred if the member is then transported by ambulance to another facility.</p> <p data-bbox="1044 1709 1511 1782">Prior authorization is required for non-emergency transport.</p> <p data-bbox="1044 1814 1471 1908">The copay is waived if you are admitted to the hospital as an inpatient.</p>

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Transportation	You pay \$0 for plan-approved transportation services.	Prior authorization is required. Unlimited one-way trips to plan-approved health-related locations every calendar year. Mileage limits may apply.
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.
Medical equipment/supplies <ul style="list-style-type: none"> <li data-bbox="110 709 532 821">• Durable medical equipment (DME) (e.g., wheelchairs, oxygen) <li data-bbox="110 898 532 1010">• Prosthetics (e.g., braces, artificial limbs) and medical supplies <li data-bbox="110 1087 391 1121">• Diabetic supplies 	<p data-bbox="565 611 1011 680">You pay 0% of the total cost of durable medical equipment.</p> <p data-bbox="565 835 1003 905">You pay 0% of the total cost of prosthetic devices.</p> <p data-bbox="565 940 1003 1010">You pay 0% of the total cost of medical supplies.</p> <p data-bbox="565 1073 1003 1142">You pay 0% of the total cost of diabetic supplies.</p> <p data-bbox="565 1178 1003 1289">You pay 0% of the total cost of diabetic therapeutic shoes or inserts.</p>	<p data-bbox="1044 611 1555 751">Prior authorization is required for all DME items with a purchase price greater than \$1,000 or \$75 per month, if rented.</p> <p data-bbox="1044 835 1555 976">Prior authorization is required for Prosthetics/Medical Supplies with a purchase price greater than \$500 or \$38.50 per month, if rented.</p> <p data-bbox="1044 1073 1563 1835">The only covered blood glucose monitors and test strips are CONTOUR[®] products manufactured by Ascensia Diabetes Care. (No authorization is required unless quantity is greater than 150 strips per 30-day supply is requested) All continuous glucose monitoring supplies require prior authorization. The only brand covered is FREESTYLE LIBRE[®] products manufactured by Abbott Diabetes Care, Inc. Alternate brands for diabetic monitoring supplies requires a prior authorization with medical necessity. Coverage is limited to one meter or continuous glucose monitoring for every 365 days.</p>

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Podiatry services (Foot care)	You pay \$0 for routine podiatry services.	There is a limit of 12 visits per year.
	You pay \$0 for Medicare-covered foot care.	Prior authorization and referrals are not required.
Chiropractic care	You pay \$0 for routine chiropractic services.	Prior authorization is required for all visits over 12 annually.
	You pay \$0 for Medicare-covered services.	Prior authorization is required for all visits over 12 annually.
Meal program (Post hospitalization)	You pay \$0.	<p>Prior authorization is required.</p> <p>You may qualify for up to 42 meals delivered to you over a 14-day period depending on your need.</p>
Food benefit	Members with End Stage Renal Disease may qualify for \$250 per month.	<p>Prior authorization and Care Coordination approval may be required.</p> <p>Other chronic conditions include: Autoimmune disorders, cancer, cardiovascular disorders, chronic and disabling mental health conditions, chronic alcohol and other drug dependence, chronic heart failure, chronic lung disorders, dementia, diabetes, end-stage liver disease, heart arrhythmias, HIV/AIDS, hypertension, morbid obesity, neurologic disorders, severe hematologic disorders, stroke.</p>
	Members with other chronic conditions (e.g., hypertension, diabetes, and more) may qualify for \$60 per month.	
	Members with Medicare's "Extra Help" may also receive a \$25 food card.	

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Fitness benefit (The Silver&Fit® Healthy Aging and Exercise Program)	You pay \$0.	Provides access to a fitness center membership at a location from the participating network and the option to select a Home Fitness kit, including, Fitbit, Garmin, yoga, strength kits and more.
Over the counter (OTC) medications and products	You receive a \$40 allowance, every month for OTC items.	Unused balances do not carry over to the next period.
Telehealth Services	You pay \$0 for primary care and \$0 for mental health services.	For Primary Care Physician services and individual sessions for mental health specialty services.

IN-NETWORK RETAIL PHARMACY OUTPATIENT PRESCRIPTION DRUGS

**Prominence Plus (HMO)
South TX - 002**

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 \$0 You pay \$12 You pay \$35 You pay \$100 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 \$4,660).	For drugs in Tiers 3, 4 and 5, you pay: <ul style="list-style-type: none"> • 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 \$7,400).	For drugs in Tiers 1, 2, 3, 4, 5 and 6 you pay: <ul style="list-style-type: none"> • \$4.15 (for generic drugs, or drugs that are treated like a generic) or • \$10.35 (all other drugs) or • 5% of the total cost (whichever is larger).

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

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

MAIL ORDER OUTPATIENT PRESCRIPTION DRUGS

**Prominence Plus (HMO)
South TX - 002**

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 \$0 You pay \$24 You pay \$70 You pay \$300 Not Available You pay \$0
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached \$4,660).	For drugs in Tiers 3, 4 and 5, you pay: <ul style="list-style-type: none"> • 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 \$7,400).	For drugs in Tiers 1,2 3, 4, 5 and 6 you pay: <ul style="list-style-type: none"> • \$4.15 (for generic drugs, or drugs that are treated like a generic) or • \$10.35 (all other drugs) or • 5% of the total cost (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 *2023 Evidence of Coverage* online at ProminenceMedicare.com.

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 of each plan year.
- 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 and HMO SNP plan with a Medicare contract and a contract with the Medicaid program. 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.

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