

FOR RESIDENTS OF
Carson City, Churchill, Douglas,
Lyon and Storey Counties

Prominence
Medicare Advantage

2025 Benefit Highlights Special Benefit Plans

Prominence Medicare
Advantage Plans

These plans have been created for people
who have specific extra coverage or conditions

Great coverage, from people who care

[ProminenceMedicare.com](https://www.ProminenceMedicare.com)

Y0109_NNVSNPBH25_M_CMS ACCEPTED

Benefit Highlights 2025 Special Benefit Plans

PREMIUMS AND BENEFITS	Prominence Extra Help (HMO)	Prominence Dual (HMO-DSNP)
Monthly Plan Premium* *You must continue to pay your Medicare Part B premium.	\$0* must have Medicare Extra Help in order to pay \$0	\$0* must have Medicare & full Medicaid
Annual Plan Deductible	\$0	\$0
Medical Maximum Out-of-Pocket	\$3,400 annually	\$9,350 annually Because members do not have copayments they will not reach this limit.
INPATIENT SERVICES	Prominence Extra Help (HMO)	Prominence Dual (HMO-DSNP)
Inpatient Hospital Coverage	\$0 - \$250 per day for days 1-6	\$0 per visit
Mental Health Hospital • Inpatient • Partial Hospitalization	\$330 per day for days 1-5 \$55 per day	\$0 per visit \$0 per visit
Skilled Nursing Facility (SNF) (Per benefit period)	\$20 for days 1-20 \$214 per day for days 21-100	\$0 per visit
OUTPATIENT CARE	Prominence Extra Help (HMO)	Prominence Dual (HMO-DSNP)
Doctor Visits • Primary Care • Specialists	\$0 per visit \$20 per visit	\$0 per visit \$0 per visit
Mental Health Outpatient	\$10 per visit	\$0 per visit
Telemedicine Services	\$0 per visit	\$0 per visit
Annual Comprehensive Physical Exam	\$0 per visit	\$0 per visit
Outpatient Surgery • Outpatient Hospital • Ambulatory Surgery Center	\$350 per visit \$25 per visit	\$0 per visit \$0 per visit
Urgent Care Copay is waived if you are admitted to the hospital as an inpatient within 3 days	\$10 per visit	\$0 per visit
Emergency Visits Copay is waived if you are admitted to the hospital as an inpatient within 3 days	\$140 per visit	\$0 per visit

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PREMIUMS AND BENEFITS	Prominence Extra Help (HMO)	Prominence Dual (HMO-DSNP)
Worldwide Emergency and Urgent Care <ul style="list-style-type: none"> • Emergency Care • Urgent Care \$25,000 maximum coverage	\$125 per visit \$30 per visit	\$125 per visit \$0 per visit
Ambulance Copay is waived if admitted to the hospital as an inpatient	\$300 per segment	\$0
Diagnostics /Labs/Imaging <ul style="list-style-type: none"> • Lab Services • Diagnostic Tests and Procedures • Outpatient X-Rays • Diagnostic Radiology Service (e.g., CT, MRI) 	\$0 \$0 \$0 \$20-\$60	\$0 \$0 \$0 \$0
Rehabilitation Services <ul style="list-style-type: none"> • Occupational Therapy Visit • Physical Therapy & Speech Language Pathology Visits 	\$5 per visit \$10 per visit	\$0 per visit \$0 per visit
Medical Equipment/Supplies <ul style="list-style-type: none"> • Diabetes Supplies (e.g. meters and test strips) • Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) 	\$0 20% coinsurance 20% coinsurance	\$0 \$0 \$0
Podiatry Services <ul style="list-style-type: none"> • Routine Foot Care Up to 12 visits per year • Medicare-covered Services 	\$10 per visit \$5 per visit	\$10 per visit \$0 per visit
Chiropractic Services <ul style="list-style-type: none"> • Routine Chiropractic Services Up to 12 visits per year • Medicare-covered Chiropractic Services 	\$10 per visit \$10 per visit	\$10 per visit \$0 per visit

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ADDITIONAL SUPPLEMENTAL BENEFITS	Prominence Extra Help (HMO)	Prominence Dual (HMO-DSNP)
Dental Services Included Dental	\$2,000 per year for preventive and comprehensive dental services \$0 copayments	\$2,000 per year for preventive and comprehensive dental services \$0 copayments
Dental – Optional Supplemental <ul style="list-style-type: none"> • Available at an additional premium • Extractions covered 	\$7,500 total allowance for preventive and comprehensive dental \$60 monthly premium Includes implants	Not included
Vision Services <ul style="list-style-type: none"> • Routine Eye Exam • Medicare-covered Eye Exam • Eyewear 	\$0 \$30 Annual benefit limit of \$200	\$0 \$0 Annual benefit limit of \$500
Hearing Services <ul style="list-style-type: none"> • Routine Hearing Exam • Medicare-covered Hearing Exam • Hearing Aid 	\$0 \$10 Annual benefit limit of \$600 per ear	\$0 \$0 Annual benefit limit of \$3,000 for both ears
Transportation One-way trips to plan-approved locations. May include rides by taxi, bus/ subway, van, or medical transport.	48 trips per year for health-related transportation services	48 trips per year for health-related transportation services + 20 non-medical one-way trips
Fitness Program Access to a fitness center membership or Home Fitness kit through the Silver&Fit® Healthy Aging and Exercise program.	No additional cost	No additional cost
Extra Benefits Card	\$50 per month For over-the-counter (OTC) drugs & supplies, healthy food & utilities (power & water) Unused balances do not carry over	\$200 per quarter For over-the-counter (OTC) drugs & supplies, healthy food & utilities (power & water) Unused balances do not carry over

The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein.

Part D Prescription Drug Coverage

RETAIL RX 30-DAY SUPPLY	Prominence Extra Help (HMO) *	Prominence Dual (HMO-DSNP)
Part D Deductible	\$0	\$0
Tier 1: Preferred Generic	You pay \$0	You pay \$0
Tier 2: Generic	You pay \$0	You pay \$0
Tier 3: Preferred Brand	You pay \$0-\$12.15	You pay \$0-\$12.15
Tier 4: Non-Preferred Drugs	You pay \$0-\$12.15	You pay \$0-\$12.15
Tier 5: Specialty Drugs	You pay \$0-\$12.15	You pay \$0-\$12.15
Tier 6: Select Care Drugs	You pay \$0	You pay \$0
Gap Coverage	\$0	\$0
Insulin	\$0	\$0
Vaccines	Most Part D vaccinations are covered at \$0	Most Part D vaccinations are covered at \$0

*** NOTE: to pay \$0-\$12.15 and no deductible for prescription drugs, you must have Medicare's Extra Help.**

INITIAL COVERAGE STAGE	CATASTROPHIC COVERAGE STAGE
You pay your share of the costs until your out-of-pocket costs reach \$2,000.	Once you move onto this last stage, you will pay \$0 for your covered Part D drugs for the rest of the year.

Prominence Health Plan is an HMO with a Medicare contract.

Enrollment in Prominence Health Plan depends on contract renewal.

For questions, please contact our Member Services number at 1-855-969-5882 (TTY: 711).

Hours are 8 a.m. to 8 p.m. seven days a week from October 1 to March 31.

From April 1 through September 30, hours are 8 a.m. to 8 p.m. Monday through Friday.

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

The logo for Prominence Health features the word "Prominence" in a dark blue, sans-serif font. A small, light blue diamond is positioned above the letter "i". Below "Prominence", the word "Health" is written in a lighter blue, sans-serif font.

www.prominencemedicare.com