2025 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Prominence Plus (HMO) H7680-002

Prominence Beyond (HMO) H7680-011

Prominence Giveback (HMO) H7680-014

South Texas Region - Standard Plans

Brooks, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy and Zapata Counties.

January 1, 2025 – December 31, 2025

SUMMARY OF BENEFITS – STANDARD PLANS

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1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, www.prominencemedicare.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Prominence Plus (HMO), Prominence Beyond (HMO) and Prominence Giveback (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Prominence Plus (HMO), Prominence Beyond (HMO)** and **Prominence Giveback (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Prominence Plus (HMO), Prominence Beyond (HMO)** and **Prominence Giveback (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-855-969-5882 (TTY: 711).

Things to Know About Prominence Plus (HMO), Prominence Beyond (HMO) and Prominence Giveback (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-855-969-5882, TTY: 711.
- If you are not a member of this plan, call us at 866-747-8855, TTY: 711.
- Our website: www.prominencemedicare.com.

Who can join?

To join **Prominence Plus (HMO), Prominence Beyond (HMO) and Prominence Giveback (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service areas for **Prominence Plus (HMO), Prominence Beyond (HMO), and Giveback (HMO)** include the following counties in Texas: Brooks, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy and Zapata.

Which doctors, hospitals, and pharmacies can I use?

Prominence Plus (HMO), Prominence Beyond (HMO) and **Prominence Giveback (HMO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.prominencemedicare.com).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.prominencemedicare.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Prominence Health Plan

2 SECTION II - SUMMARY OF BENEFITS

	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	You do not pay a separate monthly plan premium for Prominence Plus (HMO). You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for Prominence Beyond (HMO). You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for Prominence Giveback (HMO). You receive a $165 monthly credit for Medicare Part B.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: $250 for Tiers 3, 4 and 5.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	Your yearly limit(s) in this plan: • $4,150 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	Your yearly limit(s) in this plan: • $7,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Prominence Plus (HMO)**	**Prominence Beyond (HMO)**	**Prominence Giveback (HMO)**
Inpatient Hospital	**In-Network:** $150 per stay. Your physician is required to notify the plan when you are admitted.	**In-Network:** **Tier 1:** Days 1-5: $175 copay per day. Days 6-90: $0 copay per day. **Tier 2:** Days 1-5: $350 copay per day. Days 6-90: $0 copay per day. Your physician is required to notify the plan when you are admitted.	**In-Network:** **Tier 1:** Days 1-6: $285 copay per day. Days 7-90: $0 copay per day. **Tier 2:** Days 1-6: $375 copay per day. Days 7-90: $0 copay per day. Your physician is required to notify the plan when you are admitted.
Outpatient Hospital	**In-Network:** Outpatient hospital: $0 copay. Outpatient Surgery: $0 copay. Observation Services: $0 copay. May require prior authorization.	**In-Network:** Outpatient hospital: $100 copay. Outpatient Surgery: $100 copay. Observation Services: $100 copay. May require prior authorization.	**In-Network:** Outpatient hospital: $200 copay. Outpatient Surgery: $200 copay. Observation Services: $295 copay. May require prior authorization.

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 Copay May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $0 Copay May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $25 copay. May require prior authorization.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $10 copay. Referrals and prior authorization may be required for specialist visits.	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $45 copay. Referrals and prior authorization may be required for specialist visits.	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $45 copay. Referrals and prior authorization may be required for specialist visits.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-Network:** $140 copay per visit. If you are admitted to the hospital as an inpatient within 3 days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $125 copay.	**In-Network:** $140 copay per visit. If you are admitted to the hospital an inpatient within 3 days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $125 copay.	**In-Network:** $110 copay per visit. If you are admitted to the hospital an inpatient within 3 days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $125 copay.

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
	Annual maximum coverage amount of $25,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures.	Annual maximum coverage amount of $25,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures.	Annual maximum coverage amount of $25,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures.
Urgently Needed Services	**In-Network:** $0 copay per visit. $30 copay for an urgent visit outside the United States.	**In-Network:** $0 copay per visit. $0 copay for an urgent visit outside the United States.	**In-Network:** $35 copay per visit. $30 copay for an urgent visit outside the United States.

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0 copay Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay X-rays: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): $20 copay. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $0 copay Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $50 copay X-rays: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $0 copay Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $100 copay X-rays: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. May require prior authorization.
Hearing Services	**In-Network:** Medicare-covered hearing exam to diagnose and treat hearing and balance issues: $0 copay Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid: $600 toward hearing aids per year (per ear). Members must utilize Hearing Care Solutions (HCS) network for hearing aid purchase.	**In-Network:** Medicare-covered hearing exam to diagnose and treat hearing and balance issues: $0 copay Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid: $800 toward hearing aids per year (per ear). Members must utilize Hearing Care Solutions (HCS) network for hearing aid purchase.	**In-Network:** Medicare-covered hearing exam to diagnose and treat hearing and balance issues: $0 copay Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid: $600 toward hearing aids per year (per ear). Members must utilize Hearing Care Solutions (HCS) network for hearing aid purchase.

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Dental Services – Included Services	$3000 per year maximum coverage preventive and comprehensive dental services combined. **In-Network:** Preventive dental services: • Oral exam (up to 2 visit(s) every year): $0 copay. • Cleaning (up to 2 visit(s) every year): $0 copay. • Fluoride treatment (up to 2 visit(s) every year): $0 copay. • Dental X-rays (up to 1 visit(s) every year): $0 copay. Comprehensive dental services: • Endodontics Services: $0 copay. • Periodontics Services: $0 copay. • Restorative Services: $0 copay. • Prosthodontics: $0 copay. • Oral and Maxillofacial Surgery services: $0 copay.	$4000 per year maximum coverage preventive and comprehensive dental services combined. **In-Network:** Preventive dental services: • Oral exam (up to 2 visit(s) every year): $0 copay. • Cleaning (up to 2 visit(s) every year): $0 copay. • Fluoride treatment (up to 2 visit(s) every year): $0 copay. • Dental X-rays (up to 1 visit(s) every year): $0 copay. Comprehensive dental services: • Endodontics Services: $0 copay. • Periodontics Services: $0 copay. • Implant Services (up to 2 every year): $0 copay. • Restorative Services: $0 copay. • Prosthodontics: $0 copay. • Oral and Maxillofacial	$1000 per year maximum coverage preventive and comprehensive dental services combined. **In-Network:** Preventive dental services: • Oral exam (up to 2 visit(s) every year): $0 copay. • Cleaning (up to 2 visit(s) every year): $0 copay. • Fluoride treatment (up to 2 visit(s) every year): $0 copay. • Dental X-rays (up to 1 visit(s) every year): $0 copay. Comprehensive dental services: • Endodontics Services: $100 copay. • Periodontics Services: $50-$100 copay. • Restorative Services: $50 - $100 copay. • Prosthodontics: $50 - $100 copay. • Oral and Maxillofacial

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
	• Adjunctive General services: $0 copay. Members must utilize FCL Dental network of providers.	Surgery services: $0 copay. • Adjunctive General services: $0 copay. Members must utilize FCL Dental network of providers.	Surgery services: $50 - $100 copay. • Adjunctive General services: $0 - $50 copay. Members must utilize FCL Dental network of providers.
OPTIONAL SUPPLEMENTAL DENTAL SERVICES			
What is the maximum payment that this plan will pay per calendar year?	This dental plan will pay up to $7,500 maximum plan coverage limit per calendar year. $44 monthly premium. 2 implants included each year.	This dental plan will pay up to $7,500 maximum plan coverage limit per calendar year. $43 monthly premium.	This dental plan will pay up to $7,500 maximum plan coverage limit per calendar year. $47 monthly premium. 2 implants included each year.
COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)			
Vision Services	**In-Network:** Medicare-covered vision exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses (frames and lenses): Our plan pays up to $200 every year for eyewear. Must utilize National Vision Administrators (NVA) vision network of providers.	**In-Network:** Medicare-covered vision exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses (frames and lenses): Our plan pays up to $500 every year for eyewear. Must utilize National Vision Administrators (NVA) vision network of providers.	**In-Network:** Medicare-covered vision exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses (frames and lenses): Our plan pays up to $200 every year for eyewear. Must utilize National Vision Administrators (NVA) vision network of providers.

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Mental Health Care	**In-Network:** Outpatient group therapy visit: $0 copay Individual therapy visit: $0 copay Inpatient Mental Health Care: $0 copay Partial Hospitalization: $0 copay Prior Authorization is required for physician services.	**In-Network:** Outpatient group therapy visit: $5 copay Individual therapy visit: $5 copay. Inpatient Mental Health Care: $0 copay Partial Hospitalization: $0 copay Prior Authorization is required for physician services.	**In-Network:** Outpatient group therapy visit: $20 copay Individual therapy visit: $20 copay. Inpatient Mental Health Care: Days 1-5: $330 copay per day. Days 6-90: $0 copay per day. Partial Hospitalization: $0 copay Prior Authorization is required for physician services.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $50 copay per day. Prior authorization required.	**In-Network:** Days 1-20: $20 copay per day. Days 21-100: $214 copay per day. Prior authorization required.	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $214 copay per day. Prior authorization required.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $0 copay Physical therapy and speech and language therapy visit: $0 copay Prior authorization is required for visits over 12 annually.	**In-Network:** Occupational therapy visit: $10 copay. Physical therapy and speech and language therapy visit: $5 copay. Prior authorization is required for visits over 12 annually.	**In-Network:** Occupational therapy visit: $25 copay. Physical therapy and speech and language therapy visit: $25 copay. Prior authorization is required for visits over 12 annually.

Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Ambulance	**In-Network:** $275 copay per segment. A segment is transport by ambulance to the nearest appropriate facility. Copayment is waived if you are admitted to the hospital as an inpatient. Prior authorization required for **non-emergency transport.**	**In-Network:** $175 copay per segment. A segment is transport by ambulance to the nearest appropriate facility. Copayment is waived if you are admitted to the hospital as an inpatient. Prior authorization required for **non-emergency transport.**	**In-Network:** $325 copay per segment. A segment is transport by ambulance to the nearest appropriate facility. Copayment is waived if you are admitted to the hospital as an inpatient. Prior authorization required for **non-emergency transport.**
Transportation	**In-Network:** $0 copay. 24 One-way trips every year to plan-approved health-related location. Mileage limits may apply.	**In-Network:** Not Covered.	**In-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. May require prior authorization.	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. May require prior authorization.	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. May require prior authorization.

Additional Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Chiropractic Care	**In-Network:** Routine Chiropractic Care: $20 Copay per visit; 12 routine visits every year. Medicare Covered Chiropractic Care: $0 copay.	**In-Network:** Routine Chiropractic Care: $20 Copay per visit; 12 routine visits every year. Medicare Covered Chiropractic Care: $10 copay.	**In-Network:** Routine Chiropractic Care: Not covered. Medicare Covered Chiropractic Care: $15 copay.
Fitness Benefit	**In-Network:** $0 copay per month. Must utilize gym within Silver & Fit network.	**In-Network:** $0 copay per month. Must utilize gym within Silver & Fit network.	**In-Network:** $0 copay per month. Must utilize gym within Silver & Fit network.
Foot Care	**In-Network:** Routine Foot Care: $20 Copay per visit; 12 routine visits every year. Medicare Covered Podiatry: $0 copay.	**In-Network:** Routine Foot Care: $20 Copay per visit; 12 routine visits every year. Medicare Covered Podiatry: $5 copay.	**In-Network:** Routine Foot Care: Not covered. Medicare Covered Podiatry: $0 copay.
Medical Equipment/Supplies*	**In-Network:** Durable medical equipment and prosthetics: $0 copay Diabetes monitoring supplies: $0 copay Only covered monitors and test strips are Contour products. Alternate brands require prior authorization.	**In-Network:** Durable medical equipment: 20% Coinsurance Prosthetics: $0 copay Diabetes monitoring supplies: $0 copay Only covered monitors and test strips are Contour products. Alternate brands require prior authorization.	**In-Network:** Durable medical equipment and prosthetics: 20% Coinsurance Diabetes monitoring supplies: $0 copay Only covered monitors and test strips are Contour products. Alternate brands require prior authorization.

Additional Benefits/Services	Prominence Plus (HMO)	Prominence Beyond (HMO)	Prominence Giveback (HMO)
Virtual Doctor's Visits Telemedicine	**In-Network:** $0 copay per visit. See a primary care or behavioral health provider using your computer or mobile device through Teladoc. (See EOC for more details).	**In-Network:** $0 copay per visit. See a primary care or behavioral health provider using your computer or mobile device through Teladoc. (See EOC for more details).	**In-Network:** $0 copay per visit. See a primary care or behavioral health provider using your computer or mobile device through Teladoc. (See EOC for more details).
Extra Benefit Card	**In-Network:** $120 per quarter for over the counter (OTC) drugs and supplies and healthy food. Unused balances do not carry over to the next period.	**In-Network:** $135 per quarter for over the counter (OTC) drugs and supplies. Unused balances do not carry over to the next period.	**In-Network:** Not Covered.

PRESCRIPTION DRUG BENEFITS			
Benefits/Services	**Prominence Plus (HMO)**	**Prominence Beyond (HMO)**	**Prominence Giveback (HMO)**
Deductible Prescription Drug Deductible:	$0 deductible.	$0 deductible.	$250 deductible for Tiers 3, 4 and 5
Initial Coverage You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.			
	Standard Retail Cost-Sharing	**Standard Retail Cost-Sharing**	**Standard Retail Cost-Sharing**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$12 copay	$12 copay	$15 copay
Tier 3 (Preferred Brand)	$45 copay	$47 copay	$47 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$100 copay	$100 copay
Tier 5 (Specialty Tier)	33% Coinsurance	33% Coinsurance	30% Coinsurance
Tier 6 (Specialty Tier)	$0 copay	$0 copay	$0 copay
	Standard Mail Order	**Standard Mail Order**	**Standard Mail Order**
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$24 copay	$24 copay	$30 copay
Tier 3 (Preferred Brand)	$135 copay	$141 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$300 copay	$300 copay	$300 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Tier 6 (Specialty Tier)	$0 copay	$0 copay	$0 copay
Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website (www.prominencemedicare.com) for complete information about your costs for covered drugs.			
Catastrophic Amount During this payment stage, the plan pays the full cost for your covered Part D drugs.			

DISCLAIMERS

This document is available in other alternate format.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-855-969-5882 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-855-969-5882 (TTY: 711).

Prominence Plus (HMO), **Prominence Beyond (HMO)** and **Prominence Giveback (HMO)** are HMO plans with a Medicare contract. Enrollment in **Prominence Plus (HMO)**, **Prominence Beyond (HMO)** and **Prominence Giveback (HMO)** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.
The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Prominence Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Prominence Healthfirst of Texas.

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 1-855-969-5882 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.prominencemedicare.com or call 1-855-969-5882 (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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, 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, 2026.
- ☐ 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).

Connect with us

Contact Information: 1-855-969-5882, TTY:711
Organization Name: Prominence Health Plan
Organization Website:prominencemedicare.com