2022 SUMMARY *of* BENEFITS

Benefits effective January 1, 2022

Prominence Health Plan
Prominence Plus (HMO)

South Texas Region
Brooks, Hidalgo, Starr and Webb Counties

Y0109_STXSB22_M CMS Accepted

2022 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, 2022 through December 31, 2022.

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 *2022 Evidence of Coverage* booklet by calling 1-855-969-5882 (TTY users should call 711). You can also view and download the *2022 Evidence of Coverage* booklet at 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, Hidalgo, Starr, Webb

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) 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)	$2,000 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 will depend on hospital facility.	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 $0 for outpatient hospital services.	Prior authorization is required for outpatient, observation services and ambulatory surgical center services.
• Observation care	You pay $0 for all services received during observation care.	
• Ambulatory surgical center services	You pay $0 for services received at an ambulatory surgical center.	
Doctor visits • Primary care providers	You pay $0 per primary care visit.	There are no referrals required for specialist visits.
• Specialists	You pay $0 per specialist visit.	

Premiums and benefits	Prominence Plus (HMO) South TX - 002	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 *2022 Evidence of Coverage*.
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	$0 for a Free Standing Emergency Facility only. Services and other Emergency Facilities are $120 copay. You pay $120 for an emergency services visit outside the United States.	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. 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. You pay $0 for an urgent care visit outside the United States.	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. Annual maximum coverage-amount of $25,000 applies for emergency services and urgent care visits outside the United States.
Diagnostic services/ Labs/Imaging	You pay $0 for diagnostic procedures/tests and lab services.	Prior authorization is required for diagnostic and therapeutic radiological services and genetic testing lab services.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
• Diagnostic procedures/ tests and lab services • Diagnostic radiological services (such as CT scans, MRIs) • Therapeutic radiological services • Outpatient x-rays	You pay $0 for diagnostic radiological services, such as CT scans and MRIs. You pay $20 for therapeutic radiological services. You pay $0 for x-ray services.	
Hearing services	You pay $0 for a routine hearing exam. (Exams for fitting hearing aids) One exam is covered annually. You pay $0 for Medicare-covered hearing services. (Diagnostic hearing and balance exams)	Annual maximum coverage-amount of $600 for hearing aids (per ear) applies. You are responsible for any amount over the hearing aid coverage limit. All appointments must be scheduled through Hearing Care Solutions. All hearing aids must be purchased through Hearing Care Solutions. Prior authorization and referrals are not required. Member out of pocket per hearing aid varies based on technology level the member selects.
Dental services (Medicare-covered)	You pay $0 for Medicare-covered dental services.	Prior authorization and referrals are not required.

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

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Mental health services • Inpatient visits	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.	For inpatient mental health care stays, your physician is required to notify the plan when you are admitted.
• Outpatient therapy visits	You pay $0 for individual or group mental health sessions	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.
• Partial hospitalization	You pay $0 per day for partial hospitalization services.	
Skilled nursing facility	You pay $0 per day, days 1 – 20; $50 per day, days 21 – 100.	Prior authorization is required.
Physical therapy	You pay $0 per visit.	Prior authorization is required for visits over 12 annually.
Ambulance	You pay $300 per transportation segment.	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. Prior authorization is required for non-emergency transport. The copay is waived if you are admitted to the hospital as an inpatient.

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 • Durable medical equipment (e.g., wheelchairs, oxygen)	You pay 0% of the total cost of durable medical equipment.	Prior authorization is required for all DME items with a purchase price greater than $1,000 or $75 per month, if rented.
• Prosthetics (e.g., braces, artificial limbs) and medical supplies	You pay 0% of the total cost of prosthetic devices. You pay 0% of the total cost of medical supplies.	Prior authorization is required for Prosthetics/Medical 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. You pay 0% 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. (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. Coverage is limited to one meter or continuous glucose monitor for every 365 days.

Premiums and benefits	Prominence Plus (HMO) South TX - 002	What you should know
Podiatry services (foot care)	You pay $0 for Medicare-covered podiatry services. You pay $0 for routine foot care.	Prior authorization and referrals are not required.
Chiropractic care • Manipulation of the spine to correct subluxation	You pay $0 for Medicare-covered chiropractic services.	Prior authorization is required for all visits over 12 annually.
Meal program	You pay $0.	Prior authorization is required. You may qualify for up to 42 meals delivered to you over a 14-day period depending on your need
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.
Over-the-counter (OTC) medications and products	You receive a $150 allowance, every three months 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 $4,430).	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 $$7,050).	For drugs in Tiers 1,2 3, 4, 5 and 6 you pay: • $3.95 (for generic drugs, or drugs that are treated like a generic) **or** • $9.85 (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 $105 You pay $300 Not Available You pay $0
Coverage gap stage (You enter the coverage gap stage when your total drug costs have reached $4,430).	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 $7,050).	For drugs in Tiers 1,2 3, 4, 5 and 6 you pay: • $3.95 (for generic drugs, or drugs that are treated like a generic) **or** • $9.85 (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 *2022 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).

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.