# 2020 Summary of Benefits

## PruittHealth Premier (HMO I-SNP)

## H6345, Plan 001

**This is a summary of drug and health services covered by PruittHealth Premier (HMO I-SNP) January 1, 2020 - December 31, 2020.**

PruittHealth Premier (HMO I-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Call 1-844-224-3659, TTY should call 711, for more information.

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, visit our website at www.pruitthealthpremier.com, or call Member Services and request the *Evidence of Coverage*.

**To Reach Our Member Services Representatives:**

- Toll Free 1-844-224-3659, TTY/TDD should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

**To join PruittHealth Premier (HMO I-SNP), you must:**

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- reside in one of our participating nursing facilities for greater than 90 days. The plan's *Provider Directory* has a list of participating nursing facilities. You can access this list on our website www.pruitthealthpremier.com or call Member Services and ask us to send you a list.

Our service area includes these counties in North Carolina: Cabarrus, Carteret, Durham, Forsyth, Pitt, Richmond, Transylvania, Union, and Wake.

PruittHealth Premier (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.pruitthealthpremier.com. If you use providers that are not in our network, the plan may not pay for these services.

This document is also available in Braille and in large print.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year.

Limitations, copayments, and restrictions may apply.

You must continue to pay your Medicare Part B premium.

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 https://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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

| | **PruittHealth Premier (HMO I-SNP)** |
|---|---|
| **Monthly plan premium** | $26.40<br>You must continue to pay your Medicare Part B premium. |
| **Deductible** | The Part B deductible is $198. |
| **Maximum out-of-pocket amount** (does not include Part D Prescription drugs) | $6,600 |
| **Inpatient Hospital coverage** | You pay the 2020 Original Medicare cost-sharing amounts.<br>$1,408 deductible;<br>$0 copayment each day for days 1-60;<br>$352 copayment each day for days 61 to 90;<br>$704 copayment each day for days 91 to 150 (lifetime reserve days).<br><br>**Prior Authorization is required.* |
| **Outpatient Hospital coverage** | |
| Outpatient hospital services | 20% coinsurance<br>**Prior Authorization may be required.* |
| Outpatient hospital observation services | $100 copayment<br>**Prior Authorization may be required.* |
| **Doctor Visits** | |
| Primary Care Providers | $0 copayment |
| Specialists | 20% coinsurance |
| **Preventive Care** | You pay nothing.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. |

| | **PruittHealth Premier (HMO I-SNP)** |
|---|---|
| **Emergency care** | $90 copayment<br>Copayment is waived if you are admitted to a hospital within 3 days. |
| **Urgently needed services** | 20% coinsurance up to a max of $65<br>Coinsurance is waived if you are admitted to a hospital within 3 days. |
| **Diagnostic Services/Labs/Imaging** | |
| Diagnostic tests and procedures | 20% coinsurance<br>**Prior Authorization may be required.* |
| Lab services | $0 copayment<br>**Prior Authorization may be required.* |
| Diagnostic radiology services (e.g. MRI, CAT Scan) | 20% coinsurance<br>**Prior Authorization may be required.* |
| Outpatient X-rays | 20% coinsurance<br>**Prior Authorization may be required.* |
| **Hearing services** | |
| Hearing exam | 20% coinsurance of the cost for Medicare-covered hearing services. |
| *Supplemental Benefit* | |
| Routine hearing exam, fitting and evaluation for hearing aids | You pay $0 copayment for one routine hearing exam, and fitting/evaluation for hearing aids every year. |
| Hearing aids | Up to a $1,250 credit for both ears combined every two years for hearing aids.<br>**Prior Authorization may be required.* |

| | PruittHealth Premier (HMO I-SNP) |
|---|---|
| **Dental services**<br><br>Medicare-covered dental | <br><br>20% coinsurance for each Medicare-covered service.<br><br>**Prior Authorization is required.* |
| **Vision care**<br><br>Yearly eye exam for diabetic retinopathy<br><br>*Supplemental Benefit*<br>Routine eye exam<br><br>Eyeglasses, lenses, frames, contacts | <br><br>20% coinsurance for Medicare-covered services.<br><br>You pay a $0 copayment for 1 routine eye exam visit every year.<br><br>Allowance of up to $225 each year. |
| **Mental Health Services**<br><br>Inpatient visit<br><br>Outpatient group therapy visit<br><br>Outpatient individual therapy visit | <br><br>You pay the 2020 Original Medicare cost-sharing amounts.<br>$1,408 deductible;<br>$0 copayment each day for days 1-60;<br>$352 copayment each day for days 61 to 90;<br>$704 copayment each day for days 91 to 150 (lifetime reserve days).<br>**Prior Authorization may be required.*<br><br>20% coinsurance<br>**Prior Authorization is required.*<br><br>20% coinsurance<br>**Prior Authorization is required.* |
| **Skilled nursing facility (SNF) care** | $0 copayment for days 1 to 100 for each Medicare-covered skilled nursing facility stay.<br>Per stay benefit period<br>**Prior Authorization is required.* |
| **Physical Therapy** | 20% coinsurance |
| **Ambulance services**<br>Ground Ambulance | 20% coinsurance |

| | PruittHealth Premier (HMO I-SNP) |
|---|---|
| Air Ambulance | 20% coinsurance |
| **Transportation (additional routine)** | $0 copayment<br>Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by taxi, bus/subway, van, or medical transport to a plan approved health-related location. |
| **Medicare Part B prescription drugs** | |
| Chemotherapy drugs | 20% coinsurance<br>**Prior Authorization may be required.* |
| Other Part B drugs | 20% coinsurance<br>**Prior Authorization may be required.* |
| **Ambulatory Surgical Center** | 20% coinsurance<br>**Prior Authorization is required.* |
| **Medical Equipment/Supplies** | |
| Durable Medical Equipment (e.g. wheelchairs, oxygen) | 20% coinsurance<br>**Prior Authorization is required.* |
| Prosthetics (e.g., braces, artificial limbs) | 20% coinsurance<br>**Prior Authorization is required.* |
| Diabetic supplies | 20% coinsurance |
| Diabetic preferred vendor | Manufacturer limited to Medline EvenCare |
| Diabetic Therapeutic Shoes and Inserts | 20% coinsurance |
| **Foot Care (podiatry services)** | |
| Foot exams and treatment | 20% coinsurance for Medicare-covered services. |
| *Supplemental Benefit* | |
| Routine foot care | $0 copayment for 6 routine foot care visits per year. |

| | **PruittHealth Premier (HMO I-SNP)** |
|---|---|
| **Occupational or Speech Therapy** | 20% coinsurance |
| **Over-the-Counter Drugs (OTC)**<br>*Supplemental Benefit*<br>Over-the-counter benefit | Up to $20 every month. Amounts do not accumulate from month to month. |
| **Pulmonary rehabilitation services** | 20% coinsurance<br>**Prior Authorization may be required.* |

| | PruittHealth Premier (HMO I-SNP) | |
|---|---|---|
| **Outpatient Prescription Drugs** | | |
| | **Standard retail cost-sharing**<br>(in-network)<br>(up to a 30-day supply) | **Long-term care (LTC) cost-sharing**<br>(up to a 31-day supply) |
| **Deductible** | $435 for all Part D prescription drugs. | |
| **Cost-Sharing for Covered Drugs** | 25% coinsurance | 25% coinsurance |
| **Coverage Gap** | After your total drug costs (including what our plan has paid and what you have paid) reach $4,020, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs for any drug tier during the coverage gap. | |
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of:<br>• 5% coinsurance, or<br>• $3.60 copayment for generic (including brand drugs treated as generic) and a $8.95 copayment for all other drugs. | |

Cost-sharing may differ based on point-of-service (retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).

## Non-Discrimination Notice

PruittHealth Premier complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PruittHealth Premier does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**PruittHealth Premier:**

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (e.g., large print, audio, accessible electronic formats, Braille, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

**If you need these services**, contact PruittHealth Premier's Member Services at the contact information below.

If you believe that PruittHealth Premier has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: PruittHealth Premier, P.O. Box 2190, Glen Allen, VA 23058; (844) 317-9059; (TTY 711); fax: 800-335-0270; email: Compliance@pruitthealthpremier.com.

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the PruittHealth Premier Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services at the Office for Civil Rights Complaint Portal, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building Washington, DC 20201, 1-800-368-1019 TTY/TDD: 1-800-537-7637 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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# Multi-Language Interpreter Services

### Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-224-3659 (رقم هاتف الصم والبكم: 711).

### Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-224-3659（TTY：711）。

### French
ATTENTION:  Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-224-3659 (ATS : 711).

### German
ACHTUNG:  Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.  Rufnummer: 1-844-224-3659 (TTY: 711).

### Gujarati
જો તમે [ગુજરાતી] બોલો છો, તો ભાષા સહાય સેવાઓ તમારા માટે મફતઉપલબ્ધ છે. 1-844-224-3659 ને કૉલ કરો (ટી.ટી.વાય: 711).

### Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-224-3659 (TTY: 711) पर कॉल करें।

### Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.    Hu rau 1-844-224-3659 (TTY: 711).

### Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-224-3659（TTY:711）まで、お電話にてご連絡ください。

### Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-224-3659 (TTY: 711) 번으로 전화해 주십시오.

### Laotian
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າ [ພາສາລາວ], ຈະມີການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍໃດໆ ສໍາລັບທ່ານ. ຈົ່ງໂທຫາເບີ 1-844-224-3659 (TTY: 711).

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**Cambodian**
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-844-224-3659 (TTY: 711)។

**Portuguese**
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-224-3659 (TTY: 711).

**Russian**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-224-3659 (телетайп: 711).

**Spanish**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-224-3659 (TTY: 711).

**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-224-3659 (TTY: 711).

**Ukranian**
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-844-224-3659 (телетайп: 711).

**Vietnamese**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-224-3659 (TTY: 711).

# Pre-Enrollment Checklist
## PruittHealth Premier (HMO I-SNP)

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 1-844-224-3659 (TTY 711).

### 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 PruittHealthPremier.com or call 1-844-224-3659 (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.

### 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, 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).
- [ ] This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.
- [ ] This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that your condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days.

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