

2022 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, 2022 - December 31, 2022.

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 1-855-855-0759, 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 PruittHealthPremier.com, or call Member Services and request the *Evidence of Coverage*.

To Reach Our Member Services Representatives:

- Toll Free 1-855-855-0759, 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 or reside in assisted living communities and require an institutional level of care. The plan's *Provider Directory* has a list of participating nursing facilities. You can access this list on our website [PruittHealthPremier.com](https://www.pruithhealth.com) or call Member Services and ask us to send you a list.

Our service area includes these counties in North Carolina: Cabarrus, Carteret, Craven, Durham, Forsyth, Pitt, Richmond, Surry, 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 [PruittHealthPremier.com](https://www.pruithhealth.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, 2023.

Limitations, copayments, and restrictions may apply.

If you want to know more about the coverage and costs of Original Medicare, look in your current “**Medicare & You 2022**” 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	\$35.80 You must continue to pay your Medicare Part B premium.
Deductible	The Part B deductible was \$203. This is the 2021 cost sharing amount and may change in 2022. PruittHealth Premier (HMO I-SNP) will provide updated rates as soon as they are released. For the Part A deductible, you pay the 2022 Original Medicare cost-sharing amounts. These are the 2021 cost-sharing amounts and may change for 2022. \$1,484 deductible
Maximum out-of-pocket amount (does not include Part D Prescription drugs)	\$6,600
Inpatient Hospital coverage	You pay the 2022 Original Medicare cost-sharing amounts. These are the 2021 cost-sharing amounts and may change for 2022. \$1,484 deductible; \$0 copayment each day for days 1-60; \$371 copayment each day for days 61 to 90; \$742 copayment each day for days 91 to 150 (lifetime reserve days). <i>Prior authorization is required.</i>
Outpatient Hospital coverage Outpatient hospital services Outpatient hospital observation services	20% coinsurance <i>Prior authorization is required.</i> \$100 copayment <i>Prior authorization is required.</i>
Doctor Visits Primary Care Providers Specialists	\$0 copayment 20% coinsurance <i>Prior authorization is required.</i>
Preventive Care	You pay nothing.
Emergency care	\$90 copayment Copayment is waived if you are admitted to a hospital within 3 days.

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Urgently needed services	20% coinsurance up to a max of \$65 Coinsurance is waived if you are admitted to a hospital within 3 days.
Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	20% coinsurance <i>No Authorization required when services are rendered in a Nursing Facility or Physician Office.</i>
Lab services	\$0 copayment <i>No authorization required for lab services rendered in any place of service.</i> <i>Authorization required for genetic testing only.</i>
Diagnostic radiology services (e.g. MRI, CAT Scan)	20% coinsurance <i>Ultrasounds do not require authorization.</i>
Outpatient X-rays	20% coinsurance <i>X-Rays do not require authorization in nursing facility, physician's office, or hospital.</i>
Hearing services	
Hearing exam	20% coinsurance of the cost for Medicare-covered hearing services.
<i>Supplemental benefits</i>	
Routine hearing exam, fitting and evaluation for hearing aids	\$0 copayment for 1 routine hearing exam, fitting and evaluation for hearing aids every year.
Hearing aids	Up to a \$1,250 credit for both ears combined every two years for hearing aids. <i>Prior authorization is required for hearing aids only.</i>
Dental services	
Medicare-covered dental	20% coinsurance for each Medicare-covered service. <i>Authorization is for Medicare-covered comprehensive dental only.</i>
Vision care	
Yearly eye exam for diabetic retinopathy	20% coinsurance for Medicare-covered services.
<i>Supplemental benefits</i>	
Routine eye exam	You pay a \$0 copayment for 1 routine eye exam visit every year.
Eyeglasses, lenses, frames, contacts	Allowance of up to \$225 every year.

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Mental Health Services	
Inpatient visit	<p>You pay the 2022 Original Medicare cost-sharing amounts. These are the 2021 cost-sharing amounts and may change for 2022. \$1,484 deductible; \$0 copayment each day for days 1-60; \$371 copayment each day for days 61 to 90; \$742 copayment each day for days 91 to 150 (lifetime reserve days). <i>Prior authorization is required.</i></p>
Outpatient group therapy visit	<p>20% coinsurance <i>Prior authorization is required.</i></p>
Outpatient individual therapy visit	<p>20% coinsurance <i>Prior authorization is required.</i></p>
Skilled nursing facility (SNF) care	<p>\$0 copayment for days 1 to 100 for each Medicare-covered skilled nursing facility stay. Per stay benefit period <i>Authorization is only required for services provided by non-capitated providers.</i></p>
Physical Therapy	20% coinsurance
Ambulance services	
Ground Ambulance	20% coinsurance
Air Ambulance	20% coinsurance
Transportation (additional routine)	<p>\$0 copayment 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.</p>
Medicare Part B prescription drugs	
Chemotherapy drugs	<p>20% coinsurance <i>For chemotherapy, only the initial use requires authorization.</i></p>
Other Part B drugs	<p>20% coinsurance <i>Prior authorization is required for some medications.</i></p>
Ambulatory Surgical Center	<p>20% coinsurance <i>Prior authorization is required.</i></p>

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Foot Care (podiatry services) Foot exams and treatment <i>Supplemental benefits</i> Routine foot care	20% coinsurance for Medicare-covered services. \$0 copayment for 6 routine foot care visits per year.
Occupational or Speech Therapy	20% coinsurance
Over-the-Counter Drugs (OTC) <i>Supplemental benefit</i> Over-the-counter benefit	Up to \$33 every month to be used toward the purchase of over-the-counter (OTC) health and wellness products. OTC benefit list of approved items provided by the Plan. Unused credits do not roll over to the next period.

	PruittHealth Premier (HMO I-SNP)	
Outpatient Prescription Drugs		
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)
Deductible	\$480 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 \$4,430, 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 \$7,050, you pay the greater of: <ul style="list-style-type: none">• 5% coinsurance, or• \$3.95 copayment for generic (including brand drugs treated as generic) and a \$9.85 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).

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 1-855-855-0759 (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 1-855-855-0759 (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, 2023.
- ☐ 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.

PruittHealth Premier is an HMO I-SNP with a Medicare contract. Enrollment in PruittHealth Premier depends on contract renewal. 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. Out-of-network/non-contracted providers are under no obligation to treat PruittHealth Premier members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.