2024 Summary of Benefits

ProCare Advantage (HMO-POS I-SNP)

H3467, Plan 001

This is a summary of drug and health services covered by ProCare Advantage (HMO-POS I-SNP) January 1, 2024 - December 31, 2024.

ProCare Advantage (HMO-POS I-SNP) is a Medicare Advantage HMO-POS I-SNP Plan (HMO stands for Health Maintenance Organization) (I-SNP stands for Institutional Special Needs Plan) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Call 1-844-206-3719, 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 ProCareAdvantagePlan.com, or call Member Services and request the *Evidence of Coverage*.

To Reach Our Member Services Representatives:

- Toll Free 1-844-206-3719, 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 ProCare Advantage (HMO-POS 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 ProCareAdvantagePlan.com or call Member Services and ask us to send you a list.

Our service area includes these counties in Texas: Bexar, Brazoria, Collin, Dallas, Denton, Fort Bend, Hardin, Harris, Jefferson, Orange, and Tarrant.

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

This document is available for free in Spanish. (Este documento está disponible de forma gratuita en español).

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

Out-of-Network/non-contracted providers are under no obligation to treat plan 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.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You 2024"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

	ProCare Advantage (HMO-POS I-SNP)
Monthly Plan Premium *(includes both medical and drugs)*	$28.40 You must continue to pay your Medicare Part B premium.
Deductible	The Part B deductible is $240. For the Part A deductible, you pay the 2024 Original Medicare cost-sharing amounts for Inpatient Hospital or Mental Health for inpatient visits. $1,632 deductible
Maximum out-of-pocket amount (does not include Part D Prescription drugs)	From network providers: $8,850 From network and out-of-network providers combined: $8,850
Inpatient Hospital coverage	You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible; $0 copayment each day for days 1 to 60; $408 copayment each day for days 61 to 90; $816 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. *Prior authorization is required.*
Outpatient Hospital coverage	
Outpatient hospital services	20% coinsurance *Prior authorization is required.*
Outpatient hospital observation services	20% coinsurance per stay *Prior authorization is required.*
Ambulatory Surgical Center (ASC)	20% coinsurance *Prior authorization is required.*

	ProCare Advantage (HMO-POS I-SNP)
Doctor Visits	
Primary Care Providers	0% - 20% coinsurance $0 copayment for primary care SNF facility visits. 20% coinsurance for primary care consults/office visits.
Specialists	**In-Network** 20% coinsurance Members have a Point-of-Service option for Physician Specialist services. "Point-of-Service" means you can use providers outside the plan's network. *Referral is required.* *Prior authorization is required.* **Out-of-Network** 20% coinsurance
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing.
Emergency care	$90 copayment Copayment is waived if you are admitted to a hospital within 3 days.
Urgently needed services	20% coinsurance Up to a maximum of $55 per visit. Coinsurance is waived if you are admitted to a hospital within 3 days.
Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	20% coinsurance *No Authorization required when services are rendered in a Nursing Facility or Physician Office.*
Diagnostic radiology services (e.g. MRI, CAT Scan)	20% coinsurance *Diagnostic and therapeutic radiological services require authorization in the nursing facility or physician's office.*
Lab services	$0 copayment *No authorization required for lab services except for genetic testing, which does require authorization.*

	ProCare Advantage (HMO-POS I-SNP)
Outpatient X-rays	20% coinsurance *Authorization exception: X-rays do not require authorization when service is rendered in a nursing facility or physician's office. All other diagnostic and therapeutic radiological services require authorization.*
Therapeutic Radiology	20% coinsurance *Prior authorization is required.*
Hearing services	
Hearing exam	20% coinsurance for each Medicare-covered service.
Dental services	
Medicare-covered dental	20% coinsurance for each Medicare-covered service. *Prior authorization is only required for Medicare-covered comprehensive dental services.*
Supplemental benefits	
Preventive dental services	1 oral exam(s) every six months; 1 cleaning(s) every six months; 1 Fluoride treatment every year. Dental X-rays limitations are included in the *Evidence of Coverage.* All services must be provided by **Liberty Dental**. Our plan partners with Liberty Dental to provide your dental benefits. To locate a network provider or to review Liberty Dental Plan's Clinical Guidelines, you may call Member Services at 1-866-544-1942 or search the Liberty Dental online provider directory at libertydentalplan.com/procareadvantage. If you choose to use a provider outside of the network, the services you receive will not be covered. Additional Limitations and Exclusions may be found in the *Evidence of Coverage*.

	ProCare Advantage (HMO-POS I-SNP)
Vision care	
Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance for each Medicare-covered service.
For people with diabetes, screening for diabetic retinopathy is covered once per year.	20% coinsurance for each Medicare-covered service.
Eyewear after cataract surgery	20% coinsurance for each Medicare-covered service.
Glaucoma screening	$0 copayment for each Medicare-covered service.
Supplemental benefits	
Routine eye exam	$0 copayment Limited to 1 visit every year
Additional routine eyewear ○ Contact lenses ○ Eyeglasses (lenses and frames)	Up to a $175 combined credit every year.
Mental Health Services	
Inpatient visit	You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible; $0 copayment each day for days 1 to 60; $408 copayment each day for days 61 to 90; $816 copayment each day for days 91 to 150 (lifetime reserve days). *Prior authorization is required.*
Outpatient group therapy visit	20% coinsurance *Prior authorization is required.*
Outpatient individual therapy visit	20% coinsurance *Prior authorization is required.*
Skilled nursing facility (SNF) care	You pay the 2024 Original Medicare cost-sharing amounts. $0 copayment each day for days 1 to 20 for each Medicare-covered skilled nursing facility stay.

	ProCare Advantage (HMO-POS I-SNP)
	$204 copayment each day for days 21 to 100 for each Medicare-covered skilled nursing facility stay. *Prior authorization may be required. Please contact the plan for additional details.*
Physical Therapy	20% coinsurance *Prior authorization may be required. Please contact the plan for additional details.*
Ambulance services	
Ground Ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*
Air Ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*
Transportation (Non-Emergency)	Not covered
Medicare Part B prescription drugs	
Chemotherapy/ Radiation drugs	0% - 20% coinsurance *For chemotherapy, authorization is required for the initial drug approval only.*
Other Part B drugs	0% - 20% coinsurance *Prior authorization is required for some medications.*

	ProCare Advantage (HMO-POS 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	$545 for all Part D prescription drugs.	
Cost- Sharing for Covered Drugs	25% coinsurance	25% coinsurance

	ProCare Advantage (HMO-POS 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)
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, 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 $8,000, you pay nothing.	

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).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Additional Benefits

	ProCare Advantage (HMO-POS I-SNP)
In-Home Support Services Benefit	$0 copayment Members are eligible for up to $200 every year for In-Home Support Services. This benefit provides assistance with general tasks such as errands, light housekeeping, accompaniment to appointments, technology assistance, and setting appointments.
Occupational therapy	20% coinsurance *Prior authorization may be required. Please contact the plan for additional details.*

	ProCare Advantage (HMO-POS I-SNP)
Over-the-counter benefit	$0 copayment You are eligible for a $20 credit every month to be used toward the purchase of over-the-counter (OTC) health and wellness products. Please contact the plan for additional details. Unused credits do not roll over to the next period.
Podiatry services (Foot care) Foot exams and treatment *Supplemental Benefit* **Additional routine foot care**	 20% coinsurance for each Medicare-covered service. $0 copayment Limited to 4 visit(s) every year
Prescription Hospice Drugs	5% coinsurance up to a maximum of $5. Cost share is the same for in-network and out-of-network providers.
Respite Care	5% coinsurance Cost share is the same for in-network and out-of-network providers.

Pre-Enrollment Checklist

ProCare Advantage (HMO-POS 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 1-844-206-3719 (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 ProCareAdvantagePlan.com or call 1-844-206-3719 (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

- ☐ **Effect on Current Coverage.** Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ 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, 2025.
- ☐ 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).
- ☐ **For I-SNP enrollees only:** 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 skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.
- ☐ **For HMO-POS enrollees only:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, noncontracted providers may deny care.

Pre-Enrollment Checklist

ProCare Advantage (HMO-POS I-SNP)

ProCare Advantage is an HMO POS I-SNP with a Medicare contract. Enrollment in ProCare Advantage depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat ProCare Advantage 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.

ProCare Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-206-3719 (TTY 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-206-3719 (TTY 711).

Form Approved
OMB# 0938-1421

ProCare ADVANTAGE

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-206-3719. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-206-3719. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-206-3719。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-206-3719。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-206-3719. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-206-3719. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-206-3719 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-206-3719. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-206-3719 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-206-3719. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية لإلجابة عن أي أسئلة تتعلق بالصحة أو جدول االدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى االتصال بنا على 1-844-206-3719العربية
سيقوم شخص ما يتحدث بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के किए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया प्राप्त करने के किए, बस हमें 1-844-206-3719 पर फोन करें. कोई व्यक्ति जो कहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-206-3719. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-206-3719. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-206-3719. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-206-3719. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-206-3719 にお電話ください。日本語を話す人 者 が支援いたします。 これは無料のサービスです。