

Prominence Plus (HMO) offered by Prominence Health Plan

Annual Notice of Changes for 2021

You are currently enrolled as a member of Prominence Plus (HMO-POS). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**
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What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Sections 2 and 2.5 for information about benefit and cost changes for our plan.
- Check the changes in the booklet to our prescription drug coverage to see if they affect you.
 - Will your drugs be covered?
 - Are your drugs in a different tier, with different cost sharing?
 - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
 - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
 - Review the 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
 - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit [go.medicare.gov/drugprices](https://www.go.medicare.gov/drugprices). These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

- Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors, including specialists you see regularly, in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 2.3 for information about our Provider Directory.
- Think about your overall health care costs.
 - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
 - How much will you spend on your premium and deductibles?
 - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area.
 - Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
 - Review the list in the back of your Medicare & You handbook.
 - Look in Section 4.2 to learn more about your choices.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Prominence Health Plan (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

Additional Resources

- This document is available for free in Spanish and Vietnamese.
- Please contact our Member Services number at 1-855-969-5882 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30.
- This document in other formats such as Large Print and Braille.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared**

responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

About *Prominence Plus (HMO)*

- Prominence Health Plan is an HMO plan with a Medicare contract. Enrollment in Prominence Health Plan depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Prominence Health Plan. When it says “plan” or “our plan,” it means *Prominence Plus (HMO)*.

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Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for *Prominence Plus (HMO)* in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.ProminenceMedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	\$0	\$0 – no change
Deductible	\$0	\$0 - no change
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	\$4,600	\$4,600 – no change
Doctor office visits	Primary care visits: \$0 per visit In-Network care visits: \$30 per visit Out-of-network: 40% co-insurance per visit	Primary care visits: \$0 per visit Specialist visits: \$20 per visit

Cost	2020 (this year)	2021 (next year)
<p>Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</p>	<p>You pay a \$275 copayment per day, days 1 through 5;</p> <p>\$0 copayment per day, days 6 through 90. You pay \$0 for days 91 and beyond.</p>	<p>You pay a \$250 copayment per day, days 1 through 5;</p> <p>\$0 copayment per day, days 6 through 90. You pay \$0 for days 91 and beyond.</p>
<p>Part D prescription drug coverage – 30 day (See Section 2.6 for details.)</p> <p>To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).</p>	<p>Deductible: None</p> <p>Copayment/Coinsurance as applicable during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: Preferred Generic: \$0 • Drug Tier 2: Generic \$16 • Drug Tier 3: Preferred Brand \$35 • Drug Tier 4: Non-preferred Drug: \$100 • Drug Tier 5: Specialty: 33% of total cost • Drug Tier 6: Select Care Drugs: \$0 	<p>Deductible: None</p> <p>Copayment/Coinsurance as applicable during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: Preferred Generic: \$0 • Drug Tier 2: Generic \$12 • Drug Tier 3: Preferred Brand \$35 • Drug Tier 4: Non-preferred Drug: \$100 • Drug Tier 5: Specialty: 33% of total cost • Drug Tier 6: Select Care Drugs: \$0 • Select Insulin Drugs: \$12 - \$35

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2021, our plan name will change from Prominence Plus (HMO-POS) to Prominence Plus (HMO).

You will receive a new ID card with the new name Prominence Plus (HMO).

If you do nothing to change your Medicare coverage by December 7, 2020, we will automatically enroll you in our Prominence Plus (HMO). This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through Prominence Plus (HMO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Prominence Plus (HMO-POS) and the benefits you will have on January 1, 2021 as a member of Prominence Plus (HMO).

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0– No change

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs. Please see Section 7 regarding “Extra Help” from Medicare.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount	\$4,600	\$4,600 – No change
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Once you have paid \$4,600 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.ProminenceMedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.ProminenceMedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Ambulance Services	\$310 copay Copay applies per segment. A segment is transport by ambulance to the nearest appropriate facility. Another segment is incurred if the beneficiary is then transported by ambulance to another facility.	\$300 copay Copay applies per segment. A segment is transport by ambulance to the nearest appropriate facility. Another segment is incurred if the beneficiary is then transported by ambulance to another facility. Prior authorization is required for non-emergency transport.

Cost	2020 (this year)	2021 (next year)
Ambulatory Surgical Center (ASC) Services	<p>You pay a \$250 copayment for ambulatory surgical center services.</p> <p>Prior authorization is required.</p>	<p>You pay a \$25 copayment for ambulatory surgical center services.</p> <p>Prior authorization is required.</p>
Cardiac and Pulmonary Rehabilitation Services	<p>You pay a \$40 copayment for cardiac rehabilitation services/intensive cardiac rehabilitation services.</p> <p>Prior authorization is required.</p>	<p>You pay a \$10 copayment for cardiac rehabilitation services/intensive cardiac rehabilitation services.</p> <p>Prior authorization is required.</p>
Chiropractic Services	<p>You pay a \$20 copayment for Medicare-covered chiropractic services.</p> <p>Prior authorization required for all visits over 12 annually.</p>	<p>You pay a \$20 copayment for Medicare-covered chiropractic services.</p> <p>Prior authorization required for all visits over 12 annually.</p>

Dental Services (preventive and comprehensive)

You pay a \$0 copayment for Medicare-covered non-routine dental care required to treat illness or injury dental services.

Prior authorization and referrals are not required.

New for 2020

For preventive dental services the plan allows \$500 towards the following covered services:

- teeth cleaning, once every six months
- oral exam, once a year
- x-rays, once a year
- fluoride treatment, twice a year

For comprehensive dental services the plan allows \$1,500 towards the following covered services:

- Non-routine Services;
- Diagnostic Services;
- Restorative Services;
- Endodontics;
- Periodontics;
- Extractions;

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.

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

Cost	2020 (this year)	2021 (next year)
	<ul style="list-style-type: none"> • Prosthodontics, • Oral/Maxillofacial Surgery <p>\$1,500 per year maximum coverage amount for non-Medicare Part A and Part B dental services.</p> <p>Prior authorization and referrals are not required.</p>	<ul style="list-style-type: none"> • endodontics • periodontics • extractions • prosthodontics • other oral/maxillofacial surgery.
Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	20% coinsurance	0% coinsurance

Cost	2020 (this year)	2021 (next year)
Hearing	<p>You pay a \$0 copayment for a routine hearing exam. One exam is covered annually.</p>	<p>You pay \$0 for a routine hearing exam. (Exams for fitting hearing aids) One exam is covered annually.</p>
	<p>You pay a \$30 copayment for Medicare-covered hearing services.</p>	<p>You pay a \$30 copayment for Medicare-covered hearing services. (Diagnostic hearing and balance exams)</p>
	<p>Hearing aid benefit is included with no additional monthly premium.</p>	<p>Annual maximum coverage-amount of \$600 for hearing aids (per ear) applies.</p>
	<p>Member out-of-pocket per hearing aid varies based on technology level selected.</p>	<p>You are responsible for any amount over the hearing aid coverage limit. The Minimum Copayment Amount is \$0 and the Maximum Copayment amount per Hearing Aid is \$1,725 depending on level of technology selected.</p>
	<p>Annual maximum coverage amount of \$500 for hearing aids (per ear) applies.</p>	<p>All appointments should be scheduled through Hearing Care Solutions.</p>
	<p>Members will receive a negotiated plan discount on hearing aids if they purchase hearing aids from our preferred vendor, Hearing Care Solutions.</p>	<p>All hearing aids must be purchased through Hearing Care Solutions.</p>
	<p>Prior authorization and referrals are not required.</p>	<p>Prior authorization and referrals are not required.</p>

Cost	2020 (this year)	2021 (next year)
Inpatient Hospital-Acute	<p>You pay a \$280 copayment per day, days 1 through 5; \$0 copayment per day, days 6 through 90.</p> <p>For use of Medicare-covered lifetime reserve days (used if an inpatient stay lasts longer than 90 days per benefit period), you pay a \$0 copayment per day, for days 91 and beyond.</p> <p>For inpatient hospital stays, your physician is required to notify the plan when you are admitted.</p>	<p>You pay a \$250 copayment per day, days 1 through 5; \$0 copayment per day, days 6 through 90.</p> <p>For use of Medicare-covered lifetime reserve days (used if an inpatient stay lasts longer than 90 days per benefit period), you pay a \$0 copayment per day, for days 91 and beyond.</p> <p>For inpatient hospital stays, your physician is required to notify the plan when you are admitted.</p>
Meals	Not covered.	<p>Prior authorization is required.</p> <p>You may qualify for up to 42 meals delivered to you over a 14-day period depending on your need.</p>
Mental Health Specialty Services	\$20 copay	\$30 copay

Cost	2020 (this year)	2021 (next year)
<p>Outpatient Rehabilitation Services</p>	<p>In-network: You pay a \$20 copayment per visit.</p> <p>Out-of-network: 40% co-insurance per visit.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • occupational therapy • physical therapy • speech-language therapy <p>Prior authorization required for visits over 12 annually for all services.</p>	<p>You pay a \$20 copayment per visit.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • occupational therapy • physical therapy • speech-language therapy <p>Prior authorization required for visits over 12 annually for all services.</p>
<p>Over-the-Counter (OTC) Medications and Products</p>	<p>You receive a \$100 Quarterly allowance for OTC items for approved OTC items.</p> <p>Balances do not carry over to the next period if unused.</p> <p>Nicotine Replacement Therapy is not a covered product under the OTC benefit.</p> <p>For more information on OTC products, please call Member Services or visit our website. Phone numbers for Member Services and our website address are listed in Section 8 of this booklet.</p>	<p>You receive a \$35 allowance every month for OTC items.</p> <p>Unused balances do not carry over to the next period.</p> <p>The Nicotine Replacement Therapy (NRT) is covered and does not duplicate any Part D OTC or formulary drugs.</p>

Cost	2020 (this year)	2021 (next year)
<p>Outpatient Diagnostic and Therapeutic Radiological Services</p>	<p>You pay \$0 for diagnostic procedures/tests and lab services.</p>	<p>You pay \$0 for diagnostic procedures/tests and lab services.</p>
	<p>You pay a \$200 copayment for diagnostic radiological services e.g., CT, MRI, etc.</p>	<p>You pay a \$100 copayment for diagnostic radiological services e.g., CT, MRI, etc.</p>
	<p>You pay a \$55 copayment for therapeutic radiological services.</p>	<p>You pay a \$25 copayment for therapeutic radiological services.</p>
	<p>You pay a \$55 copayment for x-ray services.</p>	<p>You pay a \$25 copayment for x-ray services.</p>
	<p>If you receive multiple services at the same location on the same day, only one copayment applies per type of test/service.</p>	<p>Diagnostic and therapeutic radiological services and genetic testing lab services require prior authorization.</p>
	<p>Diagnostic and therapeutic radiological services and genetic testing lab services require prior authorization.</p>	

Cost	2020 (this year)	2021 (next year)
Outpatient Hospital Services	<p>You pay a \$325 copayment per visit for outpatient hospital services.</p> <p>You pay a \$275 copayment for all services received during observation care.</p> <p>You pay a \$50 copayment for wound care treatment services at a provider's office, ambulatory surgical center, and contracted wound care facility.</p>	<p>You pay a \$25 copayment per visit for outpatient hospital services.</p> <p>You pay a \$350 copayment for all services received during observation care.</p> <p>You pay a \$25 copayment for wound care treatment services at a provider's office, ambulatory surgical center, and contracted wound care facility.</p>
Physical Therapy (PT) and Speech-language Pathology (SP) Services	<p>PT / SP Copay:</p> <p>\$40 copay per visit</p>	<p>PT / SP Copay:</p> <p>\$20 copay per visit</p>
Physician Specialist Services excluding Psychiatric Services	<p>Specialist Copay:</p> <p>\$30 per visit</p>	<p>Specialist copay:</p> <p>\$20 per visit</p>
Transportation Services	<p>You pay a \$0 copayment for Plan Approved Health transportation services.</p> <p>Service Options include Taxi, Rideshare Van and Medical Transport Services.</p> <p>Contact the Health Plan Member Services team to arrange transportation.</p> <p>Service is limited to 20 one-way trips annually.</p>	<p>You pay a \$0 copayment for Plan approved Health transportation services.</p> <p>Service Options include Taxi, Rideshare Van and Medical Transport Services.</p> <p>Prior authorization is required.</p> <p>Service is limited to 20 one-way trips annually.</p>

Cost	2020 (this year)	2021 (next year)
Urgently Needed Services	\$35 copay	\$30 copay Members will not be required to pay the urgent care copay if admitted to the hospital as an inpatient for the same condition within 3 days of an urgent care visit.
Vision	<p>You pay a \$30 copayment for Medicare-covered eye exams including an annual glaucoma screening.</p> <p>You pay a \$20 copayment for routine eye exams.</p> <p>After cataract surgery, you pay 20% of the cost for one pair of corrective lenses/eyeglasses or one set of contact lenses. You are responsible 100% for upgrades or any non-covered service.</p> <p>You receive a \$150 annual allowance for eyewear (eyeglasses, (lenses and frames) or contact lenses).</p> <p>You pay \$0 for retinal exams.</p>	<p>You pay a \$30 copayment for Medicare-covered eye exams. (Exams to diagnose and treat diseases and conditions of the eye)</p> <p>You pay a \$0 copayment for a routine eye exam (Eye refractions for eyeglasses or contact lenses) One exam is covered annually.</p> <p>You receive a \$150 annual allowance for eyewear (eyeglasses* (lenses and frames) and contact lenses).</p> <p>Prior authorization and referrals are not required.</p> <p>You must use the National Vision Administrators (NVA) vision network of providers.</p> <p>*You are eligible for up to two (2) pairs of eyeglasses in a benefit period.</p>

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
 - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are an existing member and you have an approved Formulary exception that was approved by Prominence Health Plan in the previous year(s), your approval will still be available based off the approval letter that you received. If your formulary exception has or will expire you will need to resubmit the formulary exception for review.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2021, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we

make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by *October 1, 2020*, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at *ProminenceMedicare.com*. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage There is no deductible for Prominence Health Plan for select insulins. You pay \$12 - \$35 for a 30-day supply for select insulins.	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage 2: Initial Coverage Stage	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:
During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.	Tier 1 Preferred Generic:	Tier 1 Preferred Generic:
	You pay: \$0 per prescription	You pay \$0 per prescription
	Tier 2 Generic:	Tier 2 Generic:
	You pay \$16 per prescription	You pay \$12 per prescription
	Tier 3 Preferred Brand:	Tier 3 Preferred Brand:
	You pay \$40 per prescription	You pay \$35 per prescription
	Tier 4 Non-Preferred Brand:	Tier 4 Non-Preferred Brand:
	You pay \$100 per prescription	You pay \$100 per prescription
	Tier 5 Specialty:	Tier 5 Specialty:
	You pay 33% per prescription	You pay 33% per prescription
	Tier 6 Select Drugs	Tier 6 Select Drugs
	You pay \$0 per prescription	You pay \$0 per prescription

**Stage 2: Initial Coverage Stage
(continued)**

The costs in this row are for a one-month (30 day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.

Once your total drug costs have reached \$4,020 you will move to the next stage (the Coverage Gap Stage).

Once your total drug costs have reached \$4,130, you will move to the next stage (the Coverage Gap Stage).

For information about the costs look in Chapter 6, Section 5 of your Evidence of Coverage.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose**Section 3.1 – If you want to stay in *Prominence Plus (HMO)***

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our *Prominence Plus (HMO)*.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *Prominence Plus (HMO)*.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *Prominence Plus (HMO)*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2021.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Texas, the SHIP is called Health Information, Counseling, and Advocacy Program (HICAP)

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare

questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call *HICAP* at 1-800-307-4444. You can learn more about HICAP by visiting their website (<https://hhs.texas.gov/services/health/medicare>).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
 - Your State Medicaid Office (applications).
- **Help from your state’s pharmaceutical assistance program.** Texas has a program called Texas HIV SPAP that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Texas HIV State Pharmaceutical Assistance Program (SPAP) . For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090 .

SECTION 7 Questions?

Section 7.1 – Getting Help from *Prominence Plus (HMO)*

Questions? We’re here to help. Please call Member Services at 1-855-969-5882. (TTY only, call 711). We are available for phone calls 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. Calls to these numbers are free.

Read your 2021 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage for Prominence Plus (HMO)*. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.ProminenceMedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.ProminenceMedicare.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read Medicare & You 2021

You can read the *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or 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.

Discrimination is Against the Law

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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Prominence Health Plan:

- 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 (large print, audio, accessible electronic formats, 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 Member Services. If you believe that Prominence Health Plan 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: Member Services, 1510 Meadow Wood Lane, Reno, NV 89502, 855-969-5882, TTY/TDD: 711, or Fax 775-770-9360. You can file a grievance in person or by mail or fax. If you need help filing a grievance, 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, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

አማርኛ (Amharic):

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-855-969-5882 (TTY: 711) (መስማት ለተሳናቸው: 1-855-969-5882 (TTY: 711)).

:العربية (Arabic)

1-855-969-5882 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-969-5882 (TTY: 711) (رقم هاتف الصم والبكم: (TTY: 711)).

繁體中文 (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 1-855-969-5882 (TTY: 711)。

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-969-5882 (TTY: 711).

سراف (Farsi)

توجه: اگر به زبان فارسی گفتگو می‌نید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 1-855-969-5882 (TTY: 711) تماس بگیرید.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-969-5882 (TTY: 711).

(Hindi): ध्यान दें: यदि आप बोलत हैं तो आपका लिए मुफ्त में भाषा सहायता सवाप उपलब्ध हैं। 1-855-969-5882 (TTY: 711) पर कॉल करें।

Ilokano (Ilocano): PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-855-969-5882 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-969-5882 (TTY: 711).

日本語 (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。1-855-969-5882 (TTY: 711) まで、お電話にてご連絡ください。

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-969-5882 (TTY: 711) 번으로 전화해 주십시오.

ພາສາລາວ (Lao): ໂປດລາວ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄຸມມຸມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-969-5882 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-969-5882 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-969-5882 (TTY: 711).

Gagana fa'a Sāmoa (Samoan): MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-855-969-5882 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-969-5882 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-969-5882 (TTY: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-969-5882 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-969-5882 (TTY: 711).

Tiếng Việt (Vietnamese): 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).

وَدْرَا (Urdu)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ و زبان و مدد کی خدمات مفت میں دستیاب ہیں۔
رہیں 1-855-969-5882 (TTY: 711)۔

Prominence[®]

Health Plan

IMPORTANT PLAN DOCUMENTS AVAILABLE

- **MEDICARE ADVANTAGE PROVIDER AND PHARMACY DIRECTORY**
The Provider and Pharmacy Directory includes a list of Prominence Health Plan's network providers.
- **MEDICARE ADVANTAGE FORMULARY INFORMATION**
The formulary is a list of prescription drugs covered by Prominence Health Plan.
- **EVIDENCE OF COVERAGE (EOC)**
The EOC contains detailed information about your plan coverage.

You can access any of these documents online at ProminenceMedicare.com or have a copy of any of these documents mailed to you by calling Member Services at the number below.

If you need help finding a provider or pharmacy, information about prescription drugs or general plan information, please call Member Services at:

1-855-969-5882 (TTY: 711) from 8 a.m. to 8 p.m., seven days a week from October 1 to March 31 and Monday through Friday from April 1 through September 30. These documents will be available by October 15.

Thank you.

Prominence Health Plan is an HMO plan with a Medicare contract. Enrollment in Prominence Health Plan depends on contract renewal.

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

ATTENTION: if you speak a language other than English, language assistance services free of charge are available to you. Call 1-855-969-5882 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-969-5882 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 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).

