2021 Medicare Decision Guide

Prominence® Health Plan

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Choosing the right **Medicare Advantage Plan Option** is important, but many people aren't sure where to turn when faced with the decision.

Prominence Health Plan can help you understand your options.

ABOUT PROMINENCE HEALTH PLAN

Provider-owned health plans like Prominence Health Plan have the ability to better manage and deliver more focused, coordinated, patient-centered care that will improve member satisfaction and provider involvement in the plan.

Prominence Health Plan started in 1993 as a health maintenance organization (HMO). By focusing on flexibility, quality and affordability, Prominence Health Plan expanded its services to include HMO, PPO, POS and self-insured group products.

We are a subsidiary of Universal Health Services, Inc. (UHS), a King of Prussia PA-based company, that is one of the largest healthcare management companies in the nation and consistently ranked as one of *Fortune's* "World's Most Admired Companies".

Prominence Health Plan has Medicare Advantage (MA) HMO plans available in certain areas. Through collaboration with local providers, Prominence Health Plan continues our strong tradition of delivering focused care management and service excellence to our members.

We are providing this Medicare Decision Guide to help you navigate the complex world of Medicare coverage. And if you'd like more information about Medicare please feel free to call us at 800-992-9023.

YOUR ROADMAP TO MEDICARE!

In mapping out a future for yourself, one of the most important things you'll likely need to do is make decisions about your Medicare coverage. Medicare is the primary insurer for most Americans once they turn age 65 or become disabled.

Consider the Prominence Health Plan Medicare Decision Guide as a resource on what you need to know about how Medicare works and what you might need in terms of additional coverage to protect yourself.

The Prominence Health Plan Medicare Decision Guide contains information on:

- The main parts of Medicare Parts A & B, including optional Part D prescription drug benefits
- When to enroll in the different types of Medicare options
- Reputable contacts and resources for more information

The sooner you complete your enrollment, the quicker you can get back to enjoying your life's journey.

Take this time to familiarize yourself with this important resource. Save it and refer to it throughout your Medicare enrollment process.

MEDICARE IS A FEDERAL HEALTH INSURANCE PROGRAM FOR:

People ages 65 and older

People younger than age 65 with certain disabilities

People of all ages with end-stage renal disease or permanent kidney failure

ORIGINAL MEDICARE EXPLAINED

Part A – Hospital coverage

Most people don't pay a premium for Medicare Part A because they or their spouse already paid for it through their payroll taxes while working.

Medicare Part A helps cover:

- Inpatient care
- Skilled nursing facility
- Hospice
- Home healthcare

Part B – Medical Coverage

This coverage is for care you receive from your doctors and other healthcare providers. Most people pay a monthly premium for Part B coverage.

Medicare Part B covers:

- Doctors and other healthcare provider services
- Outpatient care
- Durable medical equipment
- Home healthcare
- Some preventive healthcare services

MEDICARE ADVANTAGE

Part C – Medicare Parts A & B Combined *(also known as Medicare Advantage)*
Medicare Advantage benefits are offered through Medicare-approved private insurance companies. Medicare Part C covers the same basic services as Medicare Parts A & B, and provides additional benefits. Most Medicare Advantage plans cover prescription drugs – Part D.

However, Medicare Part D can be sold separately. Some Medicare Advantage plans may include extra benefits such as vision, dental and hearing services at no additional cost to you. When choosing a plan, make sure you review the plan's Summary of Benefits in detail so you know the benefits that are covered or may have an additional cost.

PART D – PRESCRIPTION DRUG COVERAGE

Medicare Part D helps limit prescription drug costs. As a Medicare member you can get optional prescription drug coverage (Part D). With Medicare Part D, you have the options to:

- Enroll in a stand-alone Part D plan to go with your Original Medicare coverage
- Enroll in a Medicare Advantage (Part C) plan that includes prescription drug coverage

WHEN AM I ELIGIBLE TO JOIN MEDICARE?

As you get ready to enroll in Medicare, it is important to understand when you are eligible. You're eligible to join Medicare if the following describes you:

1. **You are 65 years old, or you are under 65 and qualify on the basis of disability or other special situations.**
2. **You are a U.S. citizen or a legal resident, who has lived in the United States for at least five consecutive years.**

Here are some things to know about the "age 65" rule.

- Even if you're already collecting Social Security, you must wait until you're 65.
- You must be 65. Your spouse's age doesn't count.
- Even if you're not collecting Social Security yet, you're eligible at age 65.

If you have questions about when you will be eligible for Medicare, you can call Prominence Health Plan, visit **medicare.gov**, or call your local Social Security Administration office for more information *(see contact information below).*

Prominence Health Plan

Please call our customer service number at 800-992-9023, (TTY: 711), 8 am to 8 pm, seven days a week from October 1st through March 31st and Monday through Friday from April 1st to September 30th.

Por favor llame a nuestro número de servicio al cliente al 855-969-5882, TTY: 711) 8 am to 8 pm, los siete días de la semana del 1 de octubre al 31 de marzo y lunes a viernes del 1 abril al 30 septiembre.

Social Security

Social Security Administration
For help with questions about eligibility for and enrolling in Medicare or Social Security retirement benefits and disability benefits, and for questions about eligibility for help with costs of Medicare coverage, call **1-800-772-1213**
TTY 1-800-325-0778
Monday through Friday: 7 am to 7 pm

Medicare

For questions about Medicare and detailed information about plans and policies available in your area, call:
1-800-MEDICARE
(1-800-633-4227) / TTY 1-877-486-2048
24 hours a day, seven days a week
Or visit **www.medicare.gov**

Administration on Aging

Eldercare Locator
For help in finding local, state and community- based organizations that serve older adults and their caregivers in your area, call: **1-800-677-1116**
Monday through Friday:
9 am to 8 pm EST
Or visit **www.eldercare.gov**

TO GET STARTED

You must initiate the enrollment process with the Social Security Administration. Go online, call or visit your local Social Security office to get the process started. The Social Security Administration handles most of the paperwork for joining Medicare. If you currently receive Social Security benefits, when you turn 65, the Social Security Administration should automatically enroll you in Medicare Part A and Part B but to be sure, check with your local Social Security office.

You can turn down Medicare Part B but you will need to call the Social Security Administration at 800-772-1213, TTY 800-325-0778 from 7 am to 7 pm to speak with someone and ask if you can do that without any later premium penalties. When you call Social Security it is important to write down the name of the person you spoke to, when you spoke to them and what they said.

WHAT HAPPENS TO THE HEALTH COVERAGE I HAVE NOW?

As you make your decisions about Medicare, keep your current health coverage in mind. This could be retiree health coverage from your former employer or union, if you've retired. If you're still working, you may have health coverage from your current job. You'll need to find out whether you can keep any coverage you currently have and what your costs might be. You may have more choices available to you than the standard choices described in this guide.

Explore your options with someone who's familiar with the details of the coverage you have now.

If it's coverage from an employer or a union, you can start with a human resources manager or a benefits specialist. You can also talk to a customer service representative at the insurance company that provides the plan. Do your research. In some cases, if you keep your current coverage and wait until later to join Medicare, you may have fewer choices and you may have to pay more.

Beneficiaries can contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627) to report changes in their insurance information or to let Medicare know if they have other insurance.

MEDICARE OPTIONS

When you enroll in Medicare, you have the option to enroll in Original Medicare (Part A and Part B) or replace your Original Medicare coverage with a Medicare Advantage (Part C) plan. They cover the same basic services, but Medicare Advantage plans often offer additional services and benefits. Your choice depends on what you need. This guide will help you understand what you're choosing. Once you decide, you'll have other choices to make. If you choose Medicare Advantage, you'll have to pick a specific Medicare Advantage plan from a particular company that provides benefits in your area. If you choose Original Medicare, you'll be receiving coverage directly through the federal government. You can also choose a Medicare Supplement plan to complement your Original Medicare plan and pick up some of the "gaps" in coverage. You may also want to buy a stand-alone Part D plan to cover outpatient prescription drugs not covered under Original Medicare.

Step 1 Enroll in Original Medicare when you become eligible.

ORIGINAL MEDICARE	
Part A	**+ Part B**
Covers hospital stays	Covers doctor and outpatient visits

Step 2 If you need more coverage, you have choices.

Keep Original Medicare and add:

MEDICARE SUPPLEMENT INSURANCE

Covers some or all of the costs not covered by Parts A & B

This optional policy can be purchased from private insurance companies to fill the gaps in Original Medicare coverage.

And/or

MEDICARE PART D

Prescription Drugs Coverage

OR

MEDICARE ADVANTAGE PLAN OPTIONS

- Provides Original Part A and B benefits and includes extra benefits
- Can be purchased from private insurance companies
- Your out-of-pocket cost for covered benefits may be lower
- Network and benefits vary by insurance companies and plan types
- Most Medicare Advantage plans include prescription drug coverage, so you don't have to buy a separate Part D plan
- Your monthly premium = Part B standard premium + MA plan premium (if any)

While original Medicare offers extensive coverage, it won't cover all your healthcare costs or prescription drugs. To bridge these gaps you have several options:

MEDICARE SUPPLEMENT PLANS

Medicare Supplement plans, or Medigap, include voluntary, additional coverage that helps fill the gaps in coverage for Original Medicare. The best time to enroll in a Medicare Supplement plan is during your individual Medigap Open Enrollment Period, which is the six-month period that begins on the first day of the month you turn 65 and have Medicare Part B. If you delay your enrollment in Medicare Part B, your Medigap open enrollment will not begin until you sign up for Part B.

During your Medigap open enrollment, you have a "guaranteed issue right" to buy any Medigap plan. This means that insurance companies cannot reject your application for a Medicare Supplement plan based on pre-existing health conditions or disabilities. They also cannot charge you a higher premium based on your health status. Outside of this one-time open enrollment, you may not be able to join any Medigap plan you want, and insurers can require you to undergo medical underwriting. You may have to pay more if you have health problems or disabilities.

Medigap plans, like Medicare Advantage plans, are offered through private insurance companies.

PLAN OPTIONS

When you join a Medicare Advantage plan, you generally get your Medicare-covered healthcare through the plan. It may include Part D prescription drug coverage. Usually there are extra benefits such as routine vision care, preventive dental services and hearing aid coverage plus lower copayments than Original Medicare. However you may have to get your care from a primary care doctor, specialists or hospitals in the plan's network except in an emergency.

Medicare pays a fixed amount for your healthcare every month to the companies offering Medicare Advantage plans.

Medicare HMOs are for individuals who take advantage of preventive care to stay healthy and who prefer working with a primary care physician to coordinate care with contracting plan specialists and hospitals. A Medicare Advantage HMO plan covers everything Original Medicare covers plus additional benefits such as hearing, vision, dental and other supplemental benefits. Benefits provided by a Medicare Advantage HMO plan may change every year.

In most Medicare Advantage PPOs, you pay less if you use primary care doctors, specialists and hospitals in the plan's network. You can go to any doctor, specialist or hospital not in the plan's network; however it will usually cost more, except in emergency or urgently needed care situations.

WHAT ARE THE DIFFERENT TYPES OF MEDICARE ADVANTAGE PLANS?

Not all types of plans are available in all areas.

HEALTH MAINTENANCE ORGANIZATION (HMO)

In most HMOs, you can only go to doctors, other healthcare providers or hospitals in the plan's network except in an urgent or emergency situation.

PREFERRED PROVIDER ORGANIZATION (PPO)

In a PPO, you pay less if you use doctors, hospitals and other healthcare providers that belong to the plan's network. You usually pay more if you use doctors, hospitals and providers outside of the network.

PRIVATE FEE-FOR-SERVICE (PFFS) PLANS:

PFFS plans are similar to Original Medicare in that you can generally go to any doctor, other healthcare provider or hospital as long as they agree to treat you. The plan determines how much it will pay doctors, other health care providers and hospitals, and how much you must pay when you get care.

SPECIAL NEEDS PLANS (SNPS)

SNPs provide focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, live in a nursing home or have certain chronic medical conditions, such as heart disease, cancer or HIV/AIDS.

HMO POINT-OF-SERVICE (HMO-POS)

These are HMO plans that may allow you to get some services out-of-network for a higher copayment or coinsurance.

MEDICAL SAVINGS ACCOUNT (MSA)

These plans combine a high-deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your healthcare services during the year. MSA plans don't offer Medicare drug coverage. If you want drug coverage, you have to join a Medicare Prescription Drug plan.

MEDICARE PRESCRIPTION DRUG PLANS (PDP)

Medicare prescription drug coverage is optional and does not occur automatically. You can receive coverage for prescription drugs by either signing up for a stand-alone Medicare Prescription Drug plan or a Medicare Advantage plan that includes drug coverage. Medicare Prescription Drug and Medicare Advantage plans are available through private insurers. Please note that you cannot have both a Prescription Drug plan and a Medicare Advantage plan that includes drug coverage. There is also a penalty for late enrollment in a PDP plan, so please check your enrollment timeline options.

MEDICARE'S EXTRA HELP PROGRAM

Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048, 24 hours a day/seven days a week; or
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

Make sure you understand how a plan works before you join.

IMPORTANT!

Make sure you understand how a plan works before you join. If you want more information about a Medicare Advantage plan, you can call any plan and request a "Summary of Benefits" (SOB) document.

WHAT ELSE SHOULD I KNOW ABOUT MEDICARE ADVANTAGE PLANS?

- You have Medicare rights and protections, including the right to appeal.
- You can check with the plan before you get a service to find out if it's covered and what your costs may be.
- You must follow plan rules. It's important to check with the plan for information about your rights and responsibilities.
- If you go to a doctor, other healthcare provider, facility or supplier that doesn't belong to the plan's network, your services may not be covered or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider.
- If you join a clinical research study, some costs may be covered by Original Medicare and some may be covered by your Medicare Advantage plan. You will need to contact the health plan before receiving services from a clinical trial to determine if your health plan will pay for services.
- Medicare Advantage plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis and skilled nursing facility care.
- Unlike Original Medicare, Medicare Advantage plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services for the rest of the year. This limit may be different between Medicare Advantage plans and can change each year. You should consider this when choosing a plan.

WHEN TO ENROLL

Applying for Medicare can be tricky. You can be penalized for enrolling too late ... or even too early. Here's how to do it right.

First, Medicare age is still 65. Most of us will enroll at 65. There are a few exceptions to get Medicare before 65. You're eligible if you're on Social Security disability for 24 months. Or you can get special ESRD Medicare (for End Stage Renal Disease) if you need a kidney transplant or dialysis. If you have ALS (Lou Gehrig's disease), you automatically get Parts A and B the month before your Social Security benefits begin. Another exception is that you can postpone Medicare until after 65 if you have health insurance from your current job.

You have three opportunities to enroll in Medicare:

You must file within seven specific months: The seven-month period starts three months before the month you turn 65, the month you turn 65, and ends three months after the month you turn 65.

Example: If you turn 65 in April, you can file anytime from January 1 to July 31. If you filed in the first three months — January-March in our example — you would have Medicare coverage starting April 1.

MEDICARE INITIAL ENROLLMENT PERIOD (IEP)						
3 months before the month you turn 65	**2 months before the month you turn 65**	**1 month before the month you turn 65**	**The month you turn 65**	**1 month after the month you turn 65**	**2 months after the month you turn 65**	**3 months after the month you turn 65**
Sign up early to avoid a delay in coverage. To get Part A and/or Part B the month you turn 65, you must sign up during the first three months before the month you turn 65.			If you wait until the last four months of your Initial Enrollment Period to sign up for Part A and/or Part B, your coverage will be delayed. *See chart below.*			

If you enroll in Part A and/or Part B the month you turn 65 or during the last three months of your Initial Enrollment Period, your start date will be delayed:

If you enroll in this month of your IEP:	Your coverage starts:
The month you turn 65	1 month after enrollment
1 month after the month you turn 65	2 months after enrollment
2 months after the month you turn 65	3 months after enrollment
3 months after the month you turn 65	3 months after enrollment

General Enrollment Period, for late enrollment

The General Enrollment Period is for late enrollees who missed the Initial and Special Enrollment Periods. Three strict penalties apply for late enrollment:

- Enrollment dates are limited to January, February and March each year.
- Coverage is postponed until July of the enrollment year. This can cause a gap in coverage.
- Finally, you will be charged a 10% late fee on your Medicare premiums for every year you were eligible but not enrolled. The penalty will apply for the rest of your life.

Medicare Advantage Annual Election Period

You can also add, drop, or change your Medicare Advantage plan during the Annual Election Period (AEP), which occurs from October 15 to December 7 of every year. During this period, you may:

- Switch from Original Medicare to Medicare Advantage, and vice versa.
- Switch from one Medicare Advantage plan to a different one.
- Switch from a Medicare Advantage plan without prescription drug coverage to a Medicare Advantage plan that covers prescription drugs, and vice versa.

Medicare Advantage Open Enrollment Period

The Medicare Advantage Open Enrollment Period (MA OEP) takes place between January 1 and March 31 of the year of coverage. The Medicare Advantage Open Enrollment Period is an opportunity to disenroll from a Medicare Advantage plan and return to original Medicare or switch to another Medicare Advantage plan.

Outside of AEP and MA OEP, you cannot make changes to your Medicare Advantage plan unless you qualify for a Special Election Period.

Your Special Enrollment Period, after 65

This applies if you are over 65, but you are covered by an employer's health insurance, either yours or your spouse's. The employee health insurance must be from your current employer, and it must be for active employees, not COBRA or retiree insurance.

If you meet those requirements, you can delay Medicare enrollment without penalties for late filing:

- You may enroll at any time while covered by the employer's health plan.
- You may enroll during the eight-month period starting with the month employment ends, or the month your employer insurance ends, whichever comes first.
- If you enroll in month one, the month of termination, your Medicare coverage starts the first day of that month.
- If you enroll after the month of termination, in months two through eight, your Medicare coverage is delayed until the month after you enroll. This could cause a gap in coverage.
- In order to avoid penalties, you must prove your employer coverage with a letter from your employer.
- You may also get a Special Enrollment Period if you move out of your plan's service area or if your plan discontinues your coverage.

LATE ENROLLMENT

Part D enrollment penalty

The late enrollment penalty is an amount that's added to your Part D premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D coverage or other creditable prescription drug coverage.

NOTE: IF YOU GET EXTRA HELP, YOU DON'T PAY A LATE ENROLLMENT PENALTY.

3 ways to avoid paying a penalty:

1. Join a Medicare drug plan when you're first eligible. Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums.

2. Don't go 63 days or more in a row without a Medicare drug plan or other creditable coverage. Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE®, Indian Health Services, the Department of Veterans Affairs, or health coverage. Your plan must tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

3. Tell your plan about any drug coverage you had if they ask about it. When you join a Medicare drug plan, and the plan believes you went at least 63 days in a row without other creditable prescription drug coverage, the plan will send you a letter. The letter will include a form asking about any drug coverage you had. Complete the form and return it to your drug plan. If you don't tell the plan about your creditable prescription drug coverage, you may have to pay a penalty.

How much more will you pay?

The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the national base beneficiary premium ($33.06 in 2021) by the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the national base beneficiary premium may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan. After you join a Medicare drug plan, the plan will tell you if you owe a penalty and what your premium will be.

ANNUAL ENROLLMENT PERIOD (AEP)

Except for the Medicare Advantage Open Enrollment Period, the Annual Enrollment Period may be the only chance you have each year to make a change to your health and prescription drug coverage (see page 14).

October 1	Medicare Advantage plans announce their new benefits. Start comparing your coverage with other options. You may be able to save money by comparing all of your options.
October 15 – December 7	This is the time to change your Medicare health or prescription drug coverage for the upcoming year, if you decide to.
January 1	New coverage begins if you make a change during Open Enrollment. New costs and benefit changes also begin if you keep your existing Medicare health or prescription drug coverage, and your plan makes changes.

JOINING AND LEAVING A MEDICARE ADVANTAGE PLAN

- You can join a Medicare Advantage plan even if you have a pre-existing condition.
- You can only join or leave a Medicare Advantage plan at certain times during the year.
- Each year, Medicare Advantage plans can choose to leave Medicare or make changes to the services they cover and what you pay. If the plan decides to stop participating in Medicare, you'll have to join another Medicare Advantage plan or return to Original Medicare.
- Medicare Advantage plans must follow certain rules when giving you information about how to join their plan.

RAILROAD RETIREMENT BOARD

If you worked at a railroad, enroll in Medicare by contacting the Railroad Retirement Board (RRB) at 1-877-772-5772 (TTY 1-312-751-4701).

If you aren't receiving retirement benefits

If you are not yet receiving retirement benefits and are close to turning 65, you can sign up for Medicare Part A and/or Part B during your IEP. If you decide to delay your Social Security retirement benefits or Railroad Retirement Benefits (RRB) beyond age 65, there is an option to enroll in just Medicare and apply for retirement benefits at a later time.

If you do not qualify for retirement benefits

If you are not eligible for retirement benefits from Social Security or the RRB, you will not be automatically enrolled into Original Medicare. However, you can still sign up for Medicare Part A and/or Part B during your IEP. You may not be able to get premium-free Medicare Part A, and the cost of your monthly Part A premium will depend on how long you worked and paid Medicare taxes. You will still have to pay a Medicare Part B premium.

GROUP RETIREE COVERAGE

If your employer offers to continue your group health coverage after you retire, carefully weigh your options. You should compare the costs and benefits of your group health coverage versus Original Medicare and a Medicare supplement policy or a Medicare Advantage plan.

In such comparisons, group health coverage isn't always the most economical. Your group health premium and cost-sharing may actually cost more than the combined total of Medicare supplement premiums and the monthly Medicare Part B premium. Also, keep in mind that some companies reserve the right to reduce or cancel retiree benefits or raise your costs including both your premiums and how much you pay when receiving benefits.

If you opt for your employer's plan, you can sign up later for Medicare Part B. To avoid any financial penalties, though, you must do so during the eight-month period that starts when your group coverage, or employment through which you received the coverage ends.

FINDING THE RIGHT PLAN FOR YOU!

The right plan for you depends on a number of factors. As you familiarize yourself with your Medicare options, consider the following:

COST

What will you pay out-of-pocket, including premiums?

Don't forget to factor in deductibles, copayments, coinsurance and out-of-pocket limits – and how much, if any, of these are covered by a particular policy.

BENEFITS

Are extra benefits and services, such as prescription drug coverage, dental, eyeglasses or hearing aids covered?

(These may be covered by some plans.)

DOCTOR AND HOSPITAL CHOICE

Can you see the doctor(s) you want to see?

Do you need a referral to see a specialist?

Can you go to the hospital you want?

What is your copayment for doctors, specialists, urgent care and hospitalization?

CONVENIENCE

Where are the doctors' offices?

What are their hours?

Is there paperwork?

Do you spend part of the year in another state?

If so, how would you be covered?

PRESCRIPTION DRUGS

Are your prescription medications on the plan's list *(formulary)* of covered drugs?

Do you get a mail order discount?

Are your drugs available at low or no copays?"

PHARMACY CHOICE

Can you use the pharmacies you want?

Are the pharmacies convenient?

QUALITY OF CARE

How is the quality of the plans in your area?

Information about quality is available at **www.medicare.gov.**

PART D COVERAGE GAP

Most Medicare drug plans have a coverage gap *(also called the "donut hole").* The coverage gap begins after you and your drug plan together have spent a certain amount for covered drugs. In 2021, once you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap because their drug costs won't be high enough and some plans provide coverage in the gap.

These items all count toward you getting out of the coverage gap:

- Your yearly deductible, coinsurance and copayments
- The discount you get on covered brand-name drugs in the coverage gap
- What you pay in the coverage gap

The drug plan premium and what you pay for drugs that aren't covered don't count toward getting you out of the coverage gap. Some plans offer additional cost-sharing reductions in the gap beyond the standard benefits and discounts on brand-name and generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would have additional cost-sharing reductions during the gap.

CATASTROPHIC COVERAGE

Once you've spent $6,550 out-of-pocket, you automatically get "catastrophic coverage." With catastrophic coverage, you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

Usually, the amount you pay for a covered prescription is for a month's supply of a drug. However, you can request less than a month's supply for most types of drugs. Some examples of when you might do this would be if you're trying a new medication that's known to have significant side effects or you want to synchronize the refills for all your medications. In these cases, the amount you pay is reduced based on the day's supply you actually get. Talk with your prescriber, because he or she will need to write you a prescription for this smaller supply.

MEDICARE ADVANTAGE COSTS

Your out-of-pocket costs in a Medicare Advantage plan (Part C) depend on:

- Whether the plan charges a monthly premium.
- Whether the plan pays any of your monthly Medicare Part B (Medical Insurance) premium.
- Whether the plan has a yearly deductible or any additional deductibles.
- How much you pay for each visit or service (copayment or coinsurance).

  For example, the plan may charge a copayment, like $0 or $20 every time you see a doctor. These amounts can be different than those under Original Medicare.
- The type of healthcare services you need and how often you get them.
- Whether you go to a doctor or supplier who accepts assignment *(if you're in a PPO, PFFS, or MSA plan and you go out-of-network).*
- Whether you follow the plan's rules, like using network providers.
- Whether you need extra benefits and if the plan charges for them.
- The plan's yearly limit on your out-of-pocket costs for all medical services.
- Whether you have Medicaid or get help from your state.

See chart on next page.

ORIGINAL MEDICARE COSTS

2021 COSTS AT A GLANCE	
Part B Premium	First time enrollees in Part B for 2021 pay $148.50. Note for beneficiaries with incomes greater than $88,000 individual or $176,000 joint please see medicare.gov for higher premium amounts.
Part B Deductible	$203 per year
Part A Premium	Most people don't pay a monthly premium for Part A. If you buy Part A, you'll pay up to $471 each month.
Part A Hospital Inpatient Deductible	You pay: – $1,484 deductible for each benefit period – Days 1-60: $0 coinsurance for each benefit period Days 61-90: $371 coinsurance per day of each benefit period Days 91 and beyond: $742 coinsurance per each "lifetime reserve day" after day 90 for each benefit period *(up to 60 days over your lifetime)* **Beyond lifetime reserve days: all costs*
Part C Premium	The Part C monthly premium varies by plan
Part D Premium	The Part D monthly premium varies by plan *(higher-income consumers may pay more)*
Coverage Gap	Most Medicare drug plans have a coverage gap *(also called the "donut hole").* This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

DEFINITIONS

Plan Deductible	The amount you must pay for healthcare or prescriptions before a plan begins to pay. This varies by plan. Some plans charge an annual deductible and some do not.
Plan Premium	The periodic payment to an insurance company or a healthcare plan for health or prescription drug coverage. Please note: our plans do not have a monthly premium.
Copayment	An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
Coinsurance	The percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. Coinsurance is usually a percentage (for example, 20%).
Cost-sharing	Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.
Maximum Out-of-Pocket Amount	The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Your Medicare Part A, Part B, plan premiums and prescription drugs do not count toward the maximum out-of-pocket amount.
Out-of-Pocket Cost	A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

MEDICARE OPTIONS AT A GLANCE

1 

Original Medicare Parts A and B

People with employer or retirement health care coverage may want to enroll in Part A, which is premium free for most people.

2 

Original Medicare Parts A and B
plus standalone Medicare Part D prescription drug plan (PDP)

3 

Original Medicare Parts A and B
plus standalone Medicare Part D prescription drug plan (PDP)
plus Medicare supplement insurance plan (Medigap)

4 

Original Medicare Parts A and B
plus Medicare supplement insurance plan (Medigap)

5 

Medicare Advantage (Part C) plan
with built-in Medicare Part D prescription drug coverage (MAPD)

6 

Medicare Advantage (Part C) plan
without Medicare Part D prescription drug coverage

7 

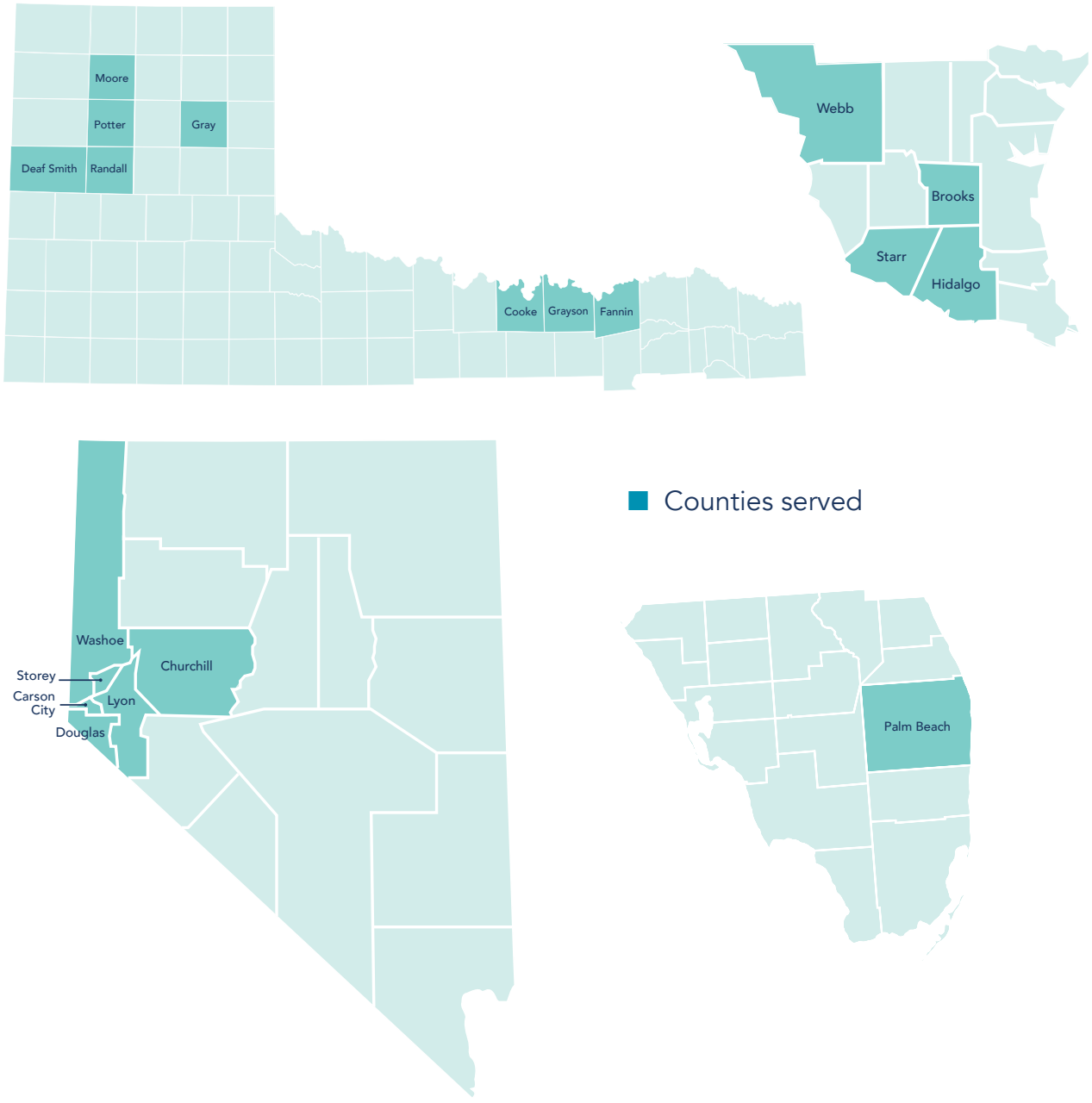
Medicare Advantage (Part C) plan
plus standalone Medicare Part D prescription drug plan
(This combination is available only if you choose a Private Fee-For-Service (PFFS) Medicare Advantage plan or a Medical Savings Account (MSA) plan, because these plans do not offer prescription drug coverage.)

Option 5 is available from Prominence Health Plan

HERE TO SERVE YOU

Healthcare is local – whether it's your doctor, your specialist, your hospital or your health plan. We serve the following areas:

- North Texas, including Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter and Randall counties
- South Texas, including Hidalgo, Starr, Brooks and Webb counties
- Nevada, including Carson City, Churchill, Douglas, Lyon, Storey and Washoe counties
- Florida, including Palm Beach county



UHS Hospitals

NORTHERN TEXAS

Northwest Texas Healthcare System
1501 S. Coulter
Amarillo, TX 79106

Texoma Medical Center
5016 South US Highway 75
Denison, TX 75020

SOUTHERN TEXAS

Cornerstone Regional Hospital
2302 Cornerstone Blvd.
Edinburg, TX 78539

(This hospital is co-owned with physician investors)

South Texas Health System Edinburg
1102 W. Trenton Rd.
Edinburg, TX 78539

South Texas Health System Heart
1900 South "D" Street
McAllen, TX 78503

South Texas Health System McAllen
301 W. Expressway 83
McAllen, TX 78503

NEVADA

Northern Nevada Medical Center
2375 E. Prater Way
Sparks, NV 89434

FLORIDA

Wellington Regional Medical Center
10101 Forest Hill Boulevard
Wellington, FL 33414

Other providers are available in our network.

To learn more about our plans or to enroll, call

TOLL FREE: **800-992-9023**

TTY: **711**

From October 1 through March 31
Monday – Sunday • 8 am – 8 pm

From April 1 through September 30
Monday – Friday • 8 am – 8 pm

We know that Medicare coverage and the decisions you need to make can be complicated and we're here to help.

You can always go online to ProminenceMedicare.com for information or call us

TOLL FREE: **800-992-9023**

TTY: **711**

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

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).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-969-5882 (TTY: 711).

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.

Prominence®
Health Plan

ProminenceMedicare.com

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