Prominence Dual (HMO D-SNP) offered by Prominence Health Plan

Annual Notice of Changes for 2023

You are currently enrolled as a member of Prominence Dual. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which 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*.

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.

- Review the changes to Medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in Prominence Dual.

- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Prominence Dual.
- Look in section 4, page 13 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish or Vietnamese.
- Please contact our Member Services number at 1-855-969-5882 for additional information. (TTY users should call 711) Hours are 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 is available in other formats such as large print, braille, and audio.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Prominence Dual

- Prominence Health Plan is an HMO and HMO Special Needs Plan (SNP) with a Medicare contract. The plan also has a written agreement with the Texas Medicaid program to coordinate your Medicaid benefits. See EOC for all eligibility qualifications.
- When this document says "we," "us," or "our," it means Prominence Health Plan. When it says "plan" or "our plan," it means Prominence Dual.

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Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Prominence Dual in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays	You pay a $0 copayment for each Medicare-covered hospital stay	You pay a $0 copayment for each Medicare-covered hospital stay
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $480 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay $0 • Drug Tier 3: You pay 25% of the total cost • Drug Tier 4: You pay $99 • Drug Tier 5: You pay 25% of the total cost • Drug Tier 6: You pay $0	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • For all covered drugs: You pay $0

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$3,450 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$3,650 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *Prominence Dual* in 2023

The information in this document tells you about the differences between your current benefits in Prominence Dual and the benefits you will have on January 1, 2023 as a member of Prominence Dual.

If you do nothing in 2022, we will automatically enroll you in our Prominence Dual. This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through Prominence Dual. If you want to change plans or switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan you must do so between October 15 and December 7. The change will take effect on January 1, 2023.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0 There is no change for the upcoming benefit year.

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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.	$3,450 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$3,650 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.ProminenceMedicare.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes. Review your *Evidence of Coverage (EOC)* for more information about available supplemental benefits.

Cost	2022 (this year)	2023 (next year)
Routine Podiatry Services	Routine Podiatry Services are not covered.	You pay a $0 copay per visit for up to 12 visits per year. Prior authorization is required.
Routine Chiropractic Services	Routine Chiropractic Services are not covered.	You pay a $0 copay per visit for up to 12 visits per year. Prior authorization is required.
Over-the-Counter Items	$330 maximum benefit every 3 months.	$50 maximum benefit every month.
Hearing Aids	$600 maximum benefit every year per ear	$3,000 maximum benefit every year both ears combined
Inpatient Hospital Acute Services – Additional Days	You pay a $0 copay per day for unlimited days per year.	After 90 days, additional days are not covered.
Inpatient Hospital Psychiatric Services – Additional Days	You pay a $0 copay per day for unlimited days per year.	After 90 days, additional days are not covered.
Supplemental Dental Services	You pay 0% coinsurance for preventive and comprehensive services. Dental services are provided through Liberty Dental.	You pay 0% coinsurance for preventive and comprehensive services. Dental services are provided through Delta Dental.

Cost	2022 (this year)	2023 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI) - Food and Produce Allowance	Members that are diagnosed with end-stage renal disease (ESRD) and participate in a care management program receive $250 per month. Members that are diagnosed with chronic heart failure or diabetes and participate in a care management program receive $100 per month. This food and produce service is provided through InComm Healthcare.	Members that are diagnosed with end-stage renal disease (ESRD) and participate in a care management program receive $250 per month. Members that are diagnosed with other chronic conditions (e.g. hypertension, chronic heart failure, diabetes, and more) and participate in a care management program receive $100 per month. See EOC for a complete list of qualifying chronic conditions. This food and produce service is provided through InComm Healthcare.
VBID – Food and Produce Allowance	VBID Food and Produce allowance is <u>not</u> available	$25 maximum benefit every month. This food and produce service is provided through InComm Healthcare. For questions regarding this benefit, 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.

Section 2.5 – 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Starting in 2023, 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.

Changes to Prescription Drug Costs

There are four "drug payment stages."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $480 During this stage, you pay $0 cost sharing for drugs on Tier 1, Tier 2, and Tier 6. Depending on your level of "Extra Help", you only have to pay the following copay amounts for drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible: For generic drugs (including brand drugs treated as generic): • $0 copay or • $1.35 copay or • $3.95 copay For all other covered drugs: • $0 copay or • $4.00 copay or • $9.85 copay	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** 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. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.* We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 - Preferred Generic:** You pay $0 per prescription. **Tier 2 - Generic:** You pay $0 per prescription. **Tier 3 - Preferred Brand:** You pay 25% of the total cost. **Tier 4 – Non-Preferred Drug:** You pay $99 per prescription. **Tier 5 – Specialty Tier:** You pay 25% of the total cost. **Tier 6 – Select Care Drugs:** You pay $0 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **For all covered drugs:** You pay $0 per prescription.
Stage 2: Initial Coverage Stage (continued)	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Changes to your VBID Part D Benefit

Starting in 2023, Prominence Health Plan is participating in the Value-Based Insurance Design Model (VBID) designed to reduce Medicare program expenditures, enhance the quality of care for Medicare enrollees (including those who have low-income subsidy (LIS) status), and

improve the coordination and efficiency of health care service delivery. As a result, you pay $0 cost share for all Part D drugs, regardless of LIS status.

SECTION 3 Administrative Changes

Description	2022 (this year)	2023 (next year)
Service Area Expansion	This plan's Service Area includes Hidalgo, Starr, Brooks, and Webb counties.	This plan's Service Area has four additional counties and now includes Hidalgo, Starr, Brooks, Webb, Cameron, Jim Hogg, Willacy, and Zapata counties.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Prominence Dual

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 Dual.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *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.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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 Dual.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Prominence Dual.
- 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 so.
    - – *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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Information, Counseling, and Advocacy Program (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 Health Information, Counseling, and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about Health Information, Counseling, and Advocacy Program (HICAP) by visiting their website (https://hhs.texas.gov/services/health/medicare).

For questions about your Texas Medicaid benefits, contact Texas Health and Human Services Commission, 1-800-252-8263 (TTY 711), available 9:00 a.m. to 5:00 p.m., Monday-Friday. You may also contact the Texas Health and Human Services Office of Ombudsman, 1-877-787-8999 (TTY 711), available Monday through Friday 8am to 5pm. Ask how joining another plan or returning to Original Medicare affects how you get your Texas Medicaid coverage.

SECTION 7 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.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas Kidney Health Center 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.

SECTION 8 Questions?

Section 8.1 – Getting Help from Prominence Health Plan

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 *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Prominence Dual. 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 8.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/medicare-and-you) 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.

Section 8.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Texas Health and Human Services Commission at 1-800-252-8263. TTY users should call 711.