Clear Spring Health Choice Plan (PPO) offered by Eon Health of South Carolina, Inc.

Annual Notice of Changes for 2021

You are currently enrolled as a member of Clear Spring Health Choice Plan (PPO) 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.**

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 *2.2* 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. 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 *Clear Spring Health Choice Plan (PPO).*
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Clear Spring Health Choice Plan (PPO).
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021.** You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at (877) 364-4566 for additional information. (TTY users should call *711*.) Hours are *October 1 – March 31, 8:00 a.m. – 8:00 p.m., seven days a week and from April 1 – September 30, 8:00 a.m. – 8:00 p.m. Monday through Friday.*

- **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 *Clear Spring Health Choice Plan (PPO)*

- *Eon Health of South Carolina, Inc. is an HMO with a Medicare contract. Enrollment in Eon Health of South Carolina, Inc. depends on contract renewal*
- When this booklet says "we," "us," or "our," it means *Eon Health of South Carolina, Inc.* When it says "plan" or "our plan," it means *Clear Spring Health Choice Plan (PPO).*

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for *Clear Spring Health Choice Plan (PPO)* 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.eonhealthplan.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.	*You pay $0.00 per month.*	*You pay $0.00 per month.*
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 2.2 for details.)	*$6,700 for in-network services. $6,700 combined for in and out-of-network services.*	*$7,550 for in-network services. $7,550 combined for in and out-of-network services.*
Doctor office visits	Primary care visits: *You pay $0 copayment* per visit. Specialist visits: *You pay $ 25 copayment* per visit	Primary care visits: *You pay $0 copayment* per visit Specialist visits: *You pay a copayment of $0 for diagnostic colonoscopies in the specialist's office and a copayment of $45* per visit for other covered specialist visits.

Cost	2020 (this year)	2021 (next year)
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.	*You pay a $395 copayment per day for days 1 – 4, $0 copayment per day for days 5 – 90 for in- network and out - of-network inpatient hospital stays. An authorization is required for Inpatient Hospital stays.*	*You pay a $285 copayment per day for days 1 – 7, $0 copayment per day for days 8 – 90 for in-network inpatient hospital stays. An authorization is required for Inpatient Hospital Stays.* *You pay a $395 copayment per day for days 1-4, $0 copayment for days 5 – 90 for out-of-network inpatient hospital stays.*
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: *You pay $150 for Tier 3, 4 and 5 prescription drugs.* *Copayment/Of the cost as applicable* during the Initial Coverage Stage. (Standard Cost Sharing): • Drug Tier 1: *You pay a $0 copayment per prescription.* • Drug Tier 2: *You pay a $10 copayment per prescription.* • Drug Tier 3: *You pay a $45 copayment per prescription.* • Drug Tier 4: *You pay a $95 copayment per prescription.* • Drug Tier 5: *You pay 28% of the total cost per prescription.*	Deductible: *You pay $200 for Tier 3, 4 and 5 prescription drugs.* *Copayment/Of the cost as applicable* during the Initial Coverage Stage. (Preferred Cost Sharing): • Drug Tier 1: *You pay a $0 copayment per prescription.* • Drug Tier 2: *You pay a $12 copayment per prescription.* • Drug Tier 3: *You pay a $42 copayment per prescription.* • Drug Tier 4: *You pay a $95 copayment per prescription.* • Drug Tier 5: *You pay 29% of the total cost per prescription.*

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2021, our plan name will change from *Eon Choice (PPO)* to *Clear Spring Health Choice Plan (PPO).*

New Member ID cards with the new plan information will be mailed out by December 7, 2020.

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.)	*You pay $0.00 per month.*	*You pay $0.00 per month.*

- 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 services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount 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.	*You maximum out-of-pockets cost is $6,700 for in-network services. Out-of-Network Services do not apply to the Maximum Out-of-Pocket.*	*Your maximum out-of-pocket cost is $7,550 for in-network services. The maximum out-ot-pocket cost of $7,550 is combined for in and out-of-network services.* Once you have paid *$7,550* out-of-pocket for covered services, you will pay nothing for your covered 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.eonhealthplan.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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at *www.eonhealthplan.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)
Inpatient Hospital Stays - Acute	*You pay a $395 copayment per day for days 1 – 4, $0 copayment per day for days 5 – 90 for in- network and out -of-network inpatient hospital stays. An authorization is required for Inpatient Hospital stays.*	*You pay a $285 copayment per day for days 1 – 7, $0 copayment per day for days 8 – 90 for in-network inpatient hospital stays. An authorization is required for Inpatient Hospital Stays.* *You pay a $395 copayment per day for days 1-4, $0 copayment for days 5 – 90 for out-of-network inpatient hospital stays.*
Inpatient Hospital Stays - Psychiatric	*You pay a $395 copayment per day for days 1 – 4, $0 copayment per day for days 5 – 90 for in- network and out -of-network inpatient hospital stays. An authorization is required for Inpatient Psychiatric Hospital stays.*	*You pay a $295 copayment per day for days 1 – 5, $0 copayment per day for days 6 – 90 for in-network inpatient hospital stays. An authorization is required for Inpatient Psychiatric Hospital Stays.* *You pay a $395 copayment per day for days 1-4, $0 copayment for days 5 – 90 for out-of-network inpatient hospital stays.*

Cost	2020 (this year)	2021 (next year)
Skilled Nursing Facility (SNF) Services	*You pay a $0 copayment per day for days 1 – 20, a copayment of $160 per day for days 21-62 and a copayment of $0 per day for days 63 – 100 for in-network SNF services. An inpatient hospital stay of at least 3 days is required prior to admission to the SNF. An authorization is required for SNF services.* *You pay a $195 copayment per day for days 1 – 35, and a copayment of $0 per day for days 36 – 100 for in-network SNF services. An inpatient hospital stay of at least 3 days is required prior to admission to the SNF. An authorization is required for SNF services.*	*You pay a $0 copayment per day for days 1 – 20, and a copayment of $167 per day for days 21 – 100 for in-network SNF Services. An inpatient hospital stay is not required prior to admission to the SNF. An authorization is required for SNF services.* *You pay a $195 copayment per day for days 1 – 35, and a copayment of $0 per day for days 36 – 100 for in-network SNF services. An inpatient hospital stay of at least 3 days is required prior to admission to the SNF. An authorization is required for SNF services.*

Cost	2020 (this year)	2021 (next year)
Cardiac and Pulmonary Rehabilitation Services	*You pay 20% of the cost per service for the following Medicare-covered **in-network and out-of-network** services: Cardiac Rehabilitation Services, Intensive Cardiac Rehabilitation Services, Pulmonary Rehabilitation Services, and Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services. An authorization is required for Cardiac and Pulmonary Rehabilitation Services.*	*You pay a $30 copayment per visit for the following Medicare-covered **in-network** services: Cardiac Rehabilitation Services, Intensive Cardiac Rehabilitation Services, Pulmonary Rehabilitation Services, and Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services. An authorization is required for Cardiac and Pulmonary Rehabilitation Services.* *You pay 20% of the cost per service for the following Medicare-covered **out-of-network services**: Cardiac Rehabilitation Services, Intensive Cardiac Rehabilitation Services, Pulmonary Rehabilitation Services, and Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services.*
Emergency / Post Stabilization Services	*You pay a $80 copayment per visit for Medicare-covered in-network and out-of-network emergency room visits.*	*You pay a $90 copayment per visit for Medicare-covered in-network and out-of-network emergency room visits.*

Cost	2020 (this year)	2021 (next year)
Physician Specialist Services (excluding Psychiatric Services)	*You pay $ 25 copayment* per visit for in-network Medicare-covered Specialist services.	*You pay a copayment of $0 for diagnostic colonoscopies in the specialist's office and a copayment of $45* per visit for other covered in-network Medicare-covered specialist services.
Mental Health Specialty Services	*You pay a $30 copayment per visit for Medicare-covered in-network group sessions. An authorization is required.*	*You pay a $40 copayment per visit for Medicare-covered in-network group sessions. An authorization* ***is not*** *required.*
Podiatry Services	*An authorization is required for in-network Medicare-covered Podiatry Services*	*An authorization is* ***not*** *required for in-network Medicare-covered Podiatry Services*
Psychiatric Services	*An authorization is required for in-network Medicare-covered Psychiatric Services.*	*An authorization is* ***not*** *required for in-network Medicare-covered Psychiatric Services.*
Physical Therapy and Speech-language Pathology Services	*An authorization is required for in-network Medicare-covered Physical Therapy and Speech-language Pathology services.*	*An authorization is required after the first 8 in-network Medicare-covered visits for Physical Therapy and Speech-language Pathology services.*
Telehealth Services	*You pay a $10 copayment per visit for in-network Medicare-covered Telehealth services. An authorization is required.*	*You pay a $0 copayment per visit for in-network Medicare-covered Telehealth services. An authorization is* ***not*** *required.*

Cost	2020 (this year)	2021 (next year)
Outpatient Diagnostic Procedures, Tests and Lab services	*An authorization is not required for Medicare-covered outpatient diagnostic procedures, tests and lab services.*	*An authorization is required for* ***non-routine*** *Medicare covered outpatient diagnostic procedures, tests and lab services.*
Outpatient Diagnostic and Therapeutic Radiological Services	*You pay 20% of the cost for in-network Medicare-covered Diagnostic Radiological services (e.g., CT, MRI, etc.).* *You pay a $14 copayment per visit for in-network Medicare-covered X-Ray Services.* *An authorization is required.*	*You pay a minimum $0 copayment per visit and a maximum $100 copayment per visit for in-network Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.).* *You pay a minimum $0 copayment per visit and a maximum $100 copayment per visit for in-network Medicare-covered X-Ray Services.* *Copay ranges are used where the copayment varies between a PCP setting and a specialist or facility setting.* *An authorization is required.*

Cost	2020 (this year)	2021 (next year)
Outpatient Hospital Services	*You pay 20% of the cost for in-network Medicare-covered Outpatient Hospital Services.* *You pay 20% of the cost for in-network Medicare-covered Observation Services.* *A referral is required for Medicare-covered Outpatient Hospital Services.*	*You pay a $250 copayment per visit for in-network Medicare-covered Outpatient Hospital Services.* *You pay a $250 copayment per visit for in-network Medicare-covered Observation Services.* *A referral is not required for Medicare-covered Outpatient Hospital Services.* *An authorization is required for Medicare-covered Observation Services after the first 24 hours.*
Ambulatory Surgical Center (ASC) Services	*You pay 20% of the cost for in-network Medicare-covered ASC services.*	*You pay a $275 copayment per visit for in-network Medicare-covered ASC services.*
Outpatient Substance Abuse Services	*You pay a $30 copayment per visit for in-network Medicare-covered group sessions.*	*You pay a $40 copayment per visit for in-network Medicare-covered group sessions.*
Outpatient Blood Services	*An authorization is required for in-network Medicare-covered Outpatient Blood Services.*	*An authorization is **not** required for in-network Medicare-covered Outpatient Blood Services.*

Cost	2020 (this year)	2021 (next year)
Ambulance Services	*You pay a $250 copayment per one-way in-network Medicare-covered trip by ground ambulance services.* *You pay a $250 copayment per one-way in-network Medicare-covered trip by air ambulance services.*	*You pay a $275 copayment per one-way in-network Medicare-covered trip by ground ambulance services.* *You pay 20% of the cost per one-way in-network Medicare-covered trip by air ambulance services.*
Diabetic Services and Supplies	*You pay $0 copayment and 0% of the cost of in-network Medicare-covered Diabetic Services and Supplies*	*You pay $0 copayment and 0% of the cost of in-network Medicare-covered Diabetic Services and Supplies*
Dialysis Services	*An authorization is required for Medicare-covered Dialysis Services.*	*An authorization is **not** required for Medicare-covered Dialysis Services*
Over the Counter (OTC) services	*The OTC maximum benefit is $15 per month for in-network items.*	*The OTC maximum benefit is $45 every 3 months for in-network items.*
Other Medicare-Covered Preventive Services	*You pay a $25 copayment per visit for in-network Medicare-covered Glaucoma Screenings. An authorization and a referral are required.* *You pay 20% of the cost for in-network Medicare-covered Diabetes Self-Management Training. A referral is required.*	*You pay 0% of the cost for in-network Medicare-covered Glaucoma Screenings. An authorization and a referral are **not** required.* *You pay 0% of the cost for in-network Medicare-covered Diabetes Self-Management Training. A referral is **not** required.*

Cost	2020 (this year)	2021 (next year)
Other (Covid-19 Public Health Emergency)	*N/A*	*If a portion of the 2021 contract year is impacted by a Public Health Emergency, Eon Health intends to offer benefits that will address the needs if affected members under prevailing circumstances. Benefits may include cost-sharing reductions, additional supplemental benefits appropriate to mitigating prevailing circumstances, or changes in Medical Management activities design to improve the quality and outcome of healthcare delivery.*
Supplemental Benefits	*Enhanced benefits include Fitness benefit, Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline.)*	*A WIFI enabled tablet pre-loaded with software applications primarily focused on allowing you conduct telehealth visits, access educational content, basic benefit information and to facilitate engagement with Clear Spring Health will be made available to any member that chooses to participate in a no cost Health Risk Assessment.*
Kidney Disease Education Services	*An authorization is not required for Medicare-covered Kidney Disease Education Services.*	*An authorization is not required for Medicare-covered Kidney Disease Education Services after the first 6 visits.*

Cost	2020 (this year)	2021 (next year)
Medicare Part B Rx Drugs	*Medicare Part B Chemotherapy Drugs and other Medicare Part B Drugs are covered.*	*Medicare Part B Chemotherapy / Radiation Drugs and other Medicare Part B Drugs are covered. An authorization is required for all Part B Drugs*
Comprehensive Dental Services	*You pay $0 copayment per visit for Comprehensive Diagnostic Services and are limited to one visit per year.* *You pay $0 copayment per visit for Comprehensive Restorative Services.* *You pay $0 copayment per visit for Prosthodontics, Other Oral/Maxillofacial Surgery and other Comprehensive Dental Services and are limited to 1 visit per year.* *A $500 maximum benefit applies to all covered in-network and out-of-network Comprehensive Dental Services.*	*Medicare-covered Comprehensive Services: You pay a $50 copayment per visit.*

Cost	2020 (this year)	2021 (next year)
Eye Exams	*You pay a $25 copayment per visit for in-network Medicare-covered eye exams.* *You pay a $10 copayment per visit for in-network routine eye exams.*	*You pay a $0 copayment per visit for routine eye exams at a PCP office and a $45 copayment per visit for in-network Medicare-covered eye exams at a specialist office or facility.* *You pay a $0 copayment per visit for in-network routine eye exams.*
Eyewear	*The combined Maximum Plan Benefit is $100.*	*The combined Maximum Plan Benefit is $200.*
Hearing Exams	*You pay a $25 copayment per visit for in-network Medicare-covered Hearing Exams.* *You pay a $25 copay per visit for in-network routine hearing exams.* *You pay a $0 copay per visit for in-network fitting/evaluation hearing aids and are limited to one visit every 3 years.*	*You pay a $45 copayment per visit for in-network Medicare-covered Hearing Exams.* *You pay a $0 copay per visit for in-network routine hearing exams.* *You pay a $0 copay per visit for in-network fitting/evaluation hearing aids and are limited to one visit every year.*
Hearing Aids	*You pay $0 cost sharing for 1 hearing aid and are limited to 1 aid every three years. The maximum benefit amount is $750. An authorization is required.*	*You pay $0 copayment per hearing aid and are limited to 2 hearing aids every three years. The maximum benefit is $750 for both ears combined. Hearing Aids must be purchased through Nations Hearing. An authorization is not required.*

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. The Drug List provided electronically includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (*www.eonhealthplan.com*).

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.

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 drugs may not apply to you.** We have included 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 didn't receive this insert with this packet, 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 *www.eonhealthplan.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 During this stage, **you pay the full cost** of your Tier 3, 4 and 5 drugs until you have reached the yearly deductible.	The deductible is $*150*. During this stage, you pay *a copay per prescription* cost sharing for drugs on *Tier 1 for Tier 2* and the full cost of drugs on *Tier 3, 4 and 5 drugs* until you have reached the yearly deductible.	The deductible is $*200* During this stage, you pay *a copay per prescription* cost sharing for drugs on *Tier 1 and Tier 2* and the full cost of drugs on *Tier 3, 4 and 5 drugs* until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and of the cost 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	2020 (this year)	2021 (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. 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 at a network pharmacy: ***Preferred Generic Drugs*:** *Standard cost sharing:* You pay a $0 copayment per prescription. ***Generic Drugs*:** *Standard cost sharing:* You pay a $10 copayment per prescription. ***Preferred Brand Drugs*:** *Standard cost sharing:* You pay a $45 copayment per prescription. ***Non-Preferred Drugs*:** *Standard cost sharing:* You pay a $95 copayment per prescription. ***Specialty Drugs*:** *Standard cost sharing:* You pay *28% of the total cost*.	Your cost for a one-month supply at a network pharmacy: ***Preferred Generic Drugs*:** *Standard cost sharing:* You pay a $5 copayment per prescription *Preferred cost sharing:* You pay a *$0 copayment per prescription.* ***Generic Drugs*:** *Standard cost sharing:* You pay a $17 copayment per prescription *Preferred cost sharing:* You pay a *$12 copayment per prescription.* ***Preferred Brand Drugs*:** *Standard cost sharing:* You pay a $47 copayment per prescription *Preferred cost sharing:* You pay a *$42 copayment per prescription.* ***Non-Preferred Drugs*:** *Standard cost sharing:* You pay a $100 copayment per prescription *Preferred cost sharing:* You pay a *$95 copayment per prescription.* ***Specialty Drugs*:** *Standard cost sharing:* You pay *29% of the total cost.* *Preferred cost sharing:* You pay *29% of the total cost.*

	Once your total drug costs have reached $*4,020*, you will move to the next stage (the Coverage Gap Stage). *OR* you have paid $*6,350* out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	**Once your total drug costs have reached $*4,130*, you will move to the next stage (the Coverage Gap Stage). *OR* you have paid *$6,550* out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).**

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 *Clear Spring Health Choice Plan (PPO)*

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 *Clear Spring Health Choice Plan (PPO).*

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 5), or call Medicare (see Section 7.2).

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.**

As a reminder, *Eon Health of South Carolina, Inc. [insert DBA names in parentheses, as applicable, after listing required MAO names throughout this document]* offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *Clear Spring Health Choice Plan (PPO)*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Clear Spring Health Choice Plan (PPO)*.
- 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 *South Carolina*, the SHIP is called *the State Health Insurance Assistance Program (SHIP) and is a program under the South Carolina Department on Aging.*

The State Health Insurance Assistance Program 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. *The State Health Insurance Assistance Program* 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 *The State Health Insurance Assistance Program* at *1-800-868-9095.* You can learn more about *The State Health Insurance Assistance Program* by visiting their website (*http://www.aging.sc.gov/*)

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 of the cost. 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.** *South Carolina* has a program called *Gap Assistance Pharmacy Program for Seniors (GAPS)* 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 6 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 *South Carolina AIDS Drug Assistance Program (ADAP)*. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-856-9954.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Clear Spring Health Choice Plan (PPO)*

Questions? We're here to help. Please call Member Services at (877) 364-4566. (TTY only, call *711*). We are available for phone calls *October 1 – March 31, 8:00 a.m. – 8:00 p.m., seven days a week and from April 1 – September 30, 8:00 a.m. – 8:00 p.m. Monday through Friday.* 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 *Clear Spring Health Choice Plan (PPO).* 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.eonhealthplan.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.eonhealthplan.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.