Explorer 6 (PPO) *offered* by PacificSource Medicare

Annual Notice of Changes for 2018

You are currently enrolled as a member of Explorer 6 (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 1.1 and 1.4 for information about benefit and cost changes for our plan.

☐ 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 website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 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 want to **keep** Explorer 6 (PPO), you don't need to do anything. You will stay in Explorer 6 (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, 2017**
   - If you **don't join by December 7, 2017**, you will stay in Explorer 6 (PPO).
   - If you join by December 7, 2017, your new coverage will start on January 1, 2018.

Additional Resources

- Please contact our Member Services number at (888) 863-3637 for additional information. (TTY users should call (800) 735-2900.) Hours are Oct. 1 - Feb. 14: 8:00 a.m. - 8:00 p.m. local time zone, seven days a week. Feb. 15 - Sept. 30: 8:00 a.m. - 8:00 p.m. local time zone, Monday – Friday.
- If you have a visual impairment and need this material in a different format such as Braille, large print, and audio tapes, please call Customer Service.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** 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 Explorer 6 (PPO)

- PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal.
- When this booklet says "we," "us," or "our," it means PacificSource Medicare. When it says "plan" or "our plan," it means Explorer 6 (PPO).

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Explorer 6 (PPO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly plan premium (See Section 1.1 for details.)	$24	$15

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From in-network providers: $4,500 From in-network and out-of-network providers combined: $6,000	From in-network providers: $6,700 From in-network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network** Primary care visits: $15 per visit Specialist visits: $35 per visit **Out-of-Network** Primary care visits: $25 per visit Specialist visits: $45 per visit	**In-Network** Primary care visits: $10 per visit Specialist visits: $35 per visit **Out-of-Network** Primary care visits: 50% co-insurance per visit Specialist visits: 50% co-insurance per visit
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.	**In-Network** Days 1-7: $275 per day Days 8+: $0 per day **Out-of-Network** Days 1-7: $375 per day Days 8+: $0 per day	**In-Network** Days 1-7: $285 per day Days 8+: $0 per day **Out-of-Network** 50% of the total cost

Annual Notice of Changes for 2018
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$24	$15
Monthly optional dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$22	$22

Section 1.2 – 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. These limits are called the "maximum out-of-pocket amounts." Once you reach this, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as co-pays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$4,500	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services from in-network providers, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.

Cost	2017 (this year)	2018 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as co-pays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$6,000	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – 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.Medicare.PacificSource.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 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, Medicare requires that we 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 and managing your care.

Section 1.4 – 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 2018 *Evidence of Coverage*.

Cost	2017 (this year)	2018 (next year)
Ambulance Services	You pay a $200 co-pay.	You pay a $250 co-pay.
Annual Physical Exam	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Cardiac Rehabilitation Services (Including Intensive Cardiac Rehabilitation)	**Out-of-network:** You pay 30% of the total cost.	**Out-of-network:** You pay 50% of the total cost.
Chiropractic Services	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Diabetes Self-Management Training, Diabetic Services and Supplies	**Out-of-network:** You pay 30% of the total cost.	**Out-of-network:** You pay 50% of the total cost.
Durable Medical Equipment (DME) and Related Supplies	**Out-of-network:** You pay 40% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Emergency care	You pay a $75 co-pay per visit.	You pay a $80 co-pay per visit.

Cost	2017 (this year)	2018 (next year)
Hearing Services: Medicare-covered	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Home Health Agency Care	**Out-of-network:** You pay 30% of the total cost.	**Out-of-network:** You pay 50% of the total cost.
Inpatient Hospital Care	**In-network:** Days 1-7: You pay a $275 co-pay per day. Days 8+: You pay a $0 co-pay per day. **Out-of-network:** Days 1-7: You pay a $375 co-pay per day. Days 8+: You pay a $0 co-pay per day.	**In-network:** Days 1-7: You pay a $285 co-pay per day. Days 8+: You pay a $0 co-pay per day. **Out-of-network:** You pay 50% of the total cost.
Inpatient Mental Health Care	**In-network:** Days 1-7: You pay a $225 co-pay per day. Days 8+: You pay a $0 co-pay per day. **Out-of-network:** Days 1-7: You pay a $325 co-pay per day. Days 8+: You pay a $0 co-pay per day.	**In-network:** Days 1-7: You pay a $230 co-pay per day. Days 8+: You pay a $0 co-pay per day. **Out-of-network:** You pay 50% of the total cost.
Medical Supplies	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Medicare Part B Prescription Drugs	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.

Cost	2017 (this year)	2018 (next year)
Medicare-covered Zero Dollar Preventive Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Other Medicare-covered Preventive Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient Blood Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient Diagnostic Procedures and Tests	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient Diagnostic radiological services	**In-network**: You pay a $125 co-pay per CT Scan, a $175 co-pay per MRI, a $175 co-pay per PET Scan, a $175 co-pay per Nuclear test **Out-of-Network:** You pay 30% of the total cost.	**In-network**: You pay a $190 co-pay per CT Scan, a $310 co-pay per MRI, a $310 co-pay per PET Scan, a $190 co-pay per Nuclear test **Out-of-Network:** You pay 50% of the total cost.
Outpatient Lab Services	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient Mental Health Care	**In-network:** You pay a $40 co-pay per visit. **Out-of-Network:** You pay 30% of the total cost.	**In-network:** You pay a $20 co-pay per visit. **Out-of-Network:** You pay 50% of the total cost.
Outpatient Rehabilitation Services: Occupational Therapy	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.

Cost	2017 (this year)	2018 (next year)
Outpatient Rehabilitation Services: Physical, and Speech Language Therapy	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient Substance Abuse Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** Outpatient Hospital Facilities You pay a $275 co-pay per visit. Ambulatory Surgical Centers You pay a $275 co-pay per visit. **Out-of-Network**: Outpatient Hospital Facilities You pay a $350 co-pay per visit. Ambulatory Surgical Centers You pay a $350 co-pay per visit.	**In-Network:** Outpatient Hospital Facilities You pay a $285 co-pay per visit. Ambulatory Surgical Centers You pay a $285 co-pay per visit. **Out-of-Network:** You pay 50% of the total cost.
Outpatient Therapeutic radiological services	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Outpatient X-ray services	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Partial Hospitalization Services	**Out-of-network:** You pay a $45 co-pay per visit.	**Out-of-network:** You pay 50% of the total cost.
Physician/ **Practioner Services:** Non-Routine Dental Care	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.

Cost	2017 (this year)	2018 (next year)
Physician/Practitioner Services, Including Doctor Office Visits: Primary Care Provider (PCP), Specialist, and Other health care professionals	**In-network:** PCP Office: You pay a $15 co-pay per visit. **Out-of-Network:** PCP Office: You pay a $25 co-pay per visit. Specialist Office: You pay a $45 co-pay per visit.	**In-network:** PCP Office: You pay a $10 co-pay per visit. **Out-of-Network:** You pay 50% of the total cost.
Podiatry Services	**Out-of-Network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Prosthetic Devices and Related Supplies	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Pulmonary Rehabilitation Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-network:** You pay 50% of the total cost.
Services to Treat Kidney Disease and Conditions: Kidney Disease Education Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Services to Treat Kidney Disease and Conditions: Outpatient Dialysis Services	**Out-of-network:** You pay 30% of the total cost.	**Out-of-network:** You pay 50% of the total cost.

Cost	2017 (this year)	2018 (next year)
Skilled Nursing Facility (SNF) Care	**In-Network:** Days 1-20: You pay a $0 co-pay per day. Days 21-100: You pay a $150 co-pay per day. **Out-of-Network:** You pay 30% of the total cost.	**In-Network:** Days 1-20: You pay a $0 co-pay per day. Days 21-100: You pay a $167 co-pay per day. **Out-of-Network:** You pay 50% of the total cost.
Sleep Studies	**Out-of-network:** You pay 30% of the total cost.	**Out-of-network:** You pay 50% of the total cost.
Urgently Needed Services	You pay a $35 co-pay per visit.	You pay a $40 co-pay per visit.
Vision Care - Routine: Refractive Eye Exams	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.
Vision Care: Medicare-Covered Eye Exam	**Out-of-network:** You pay 30% of the total cost.	**Out-of-Network:** You pay 50% of the total cost.

SECTION 2 Administrative Changes

Cost	2017 (this year)	2018 (next year)
Home Health prior authorization requirement	Prior authorization required for Home Health Services	No prior authorization required for Home Health Services

Cost	2017 (this year)	2018 (next year)
Part B Prescription Drugs: Prior Authorization requirements	Prior authorization requirements for Part B drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part B drugs require prior authorization.	Prior authorization requirements for Part B drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part B drugs require prior authorization.
TruHearing Hearing Aids (name change)	TruHearing Flyte 700 and Flyte 900	TruHeairng Flyte Advanced and Flyte Premium

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Explorer 6 (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 stay enrolled as a member of our plan for 2018.

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 2018 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, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (SHIP) (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 and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, PacificSource Medicare offers other Medicare health plans and Medicare prescription drug 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 Explorer 6 (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Explorer 6 (PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Service 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, 2018.

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 are allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 8, Section 3.1 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 Idaho, the SHIP is called Senior Health Insurance Benefits Advisors (SHIBA).

SHIBA 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. SHIBA 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 SHIBA at:

State:	Phone:	Website:
Idaho	(800) 247-4422	www.DOI.Idaho.gov/shiba

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:

- 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 co-insurance. 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, 24hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7:00 a.m. and 7:00 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the:
    - Idaho AIDS Drug Assistance Program.

  Note: To be eligible for the ADAP operating in your State, 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.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

State:	Program:	Phone:
Idaho	Idaho AIDS Drug Assistance Program	(208) 334-5943

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

State:	Program:	Phone:
Idaho	Idaho AIDS Drug Assistance Program	(208) 334-5943

SECTION 7 Questions?

Section 7.1 – Getting Help from Our Plan

Questions? We're here to help. Please call Customer Service toll-free at (888) 863-3637. (TTY only, call (800) 735-2900.) We are available for phone calls: **October 1 - February 14**: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. **February 15 - September 30**: 8:00 a.m. to 8:00 p.m. local time zone, Monday-Friday. Calls to this number are free.

Read your 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for Explorer 6 (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 included in this envelope.

Visit Our Website.

You can also visit our website at www.Medicare.PacificSource.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

You can call 1-800-MEDICARE or (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 and click on "Find health & drug plans.")

Read *Medicare & You 2018*.

You can read *Medicare & You 2018* 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.