PacificSource Medicare

Essentials Choice 2 (HMO-POS) *offered by* PacificSource Medicare

Annual Notice of Changes for 2025

You are currently enrolled as a member of Essentials Choice 2 (HMO-POS). 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.Medicare.PacificSource.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **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.
- Review the changes to medical care costs (doctor, hospital).
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Essentials Choice 2 (HMO-POS).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Essentials Choice 2 (HMO-POS).
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Customer Service number toll-free at 888-863-3637 for additional information (TTY: 711. We accept all relay calls.). Hours are: **October 1 - March 31:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. **April 1 - September 30:** 8:00 a.m. to 8:00 p.m. local time zone, Monday-Friday. This call is free.
- If you have a visual impairment and need this material in a different format such as braille, large print, audio, or other alternate formats, please call Customer Service.
- **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 Essentials Choice 2 (HMO-POS)

- PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid).
- When this booklet says "we," "us," or "our", it means PacificSource Medicare. When it says "plan" or "our plan," it means Essentials Choice 2 (HMO-POS).
- This plan does not include Medicare Part D prescription drug coverage and you cannot be enrolled in a separate Medicare Part D prescription drug plan and this plan at the same time. Note: If you do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for our plan in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium (See Section 1.1 for details.)	$0	$0
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 1.2 for details.)	**In-Network** $3,950 **In-Network and Out-of-Network combined** $8,950	**In-Network** $5,950 **In-Network and Out-of-Network combined** $8,950
Doctor office visits	**In-Network** Primary care visits: $0 per visit Specialist visits: $0 per visit **Out-of-Network** Primary care visits: $45 per visit Specialist visits: $45 per visit	**In-Network** Primary care visits: $10 per visit Specialist visits: $10 per visit **Out-of-Network** Primary care visits: $45 per visit Specialist visits: $45 per visit
Inpatient hospital stays	**In-Network** Days 1-5: $250 per day Days 6+: $0 per day **Out-of-Network** 30% of the total cost	**In-Network** Days 1-7: $425 per day Days 8+: $0 per day **Out-of-Network** 30% of the total cost

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

Section 1.2 – 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	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount.	$3,950	$5,950 Once you have paid $5,950 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$8,950	$8,950 Once you have paid $8,950 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

Updated directores are 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 directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 Provider Directory www.Medicare.PacificSource.com/Search/Provider 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. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Acupuncture for chronic low back pain (Medicare covered)	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay a $10 copay per visit.
Alternative Care Naturopathic, and non-Medicare covered acupuncture and chiropractic care	You pay a $0 copay per visit up to a combined total of 24 office visits.	You pay a $10 copay per visit up to a combined total of 24 office visits.
Chiropractic services: Medicare covered	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay a $10 copay per visit.
Fitness Benefit	Must use Silver&Fit.	Must use One Pass You pay a $0 copay for the following: • Access to a nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to help improve your memory and focus • Groups, clubs and social events near you To learn more, go to YourOnePass.com, or contact One Pass at 877-504-6830.
Global emergency and travel assistance Assist America, INC.	**In-Network** You pay a $0 copay for covered services. **Out-of-Network** Must use Assist America.	Global emergency and travel assistance program is not covered.

Cost	2024 (this year)	2025 (next year)
Inpatient hospital care	**In-Network** Days 1-5: You pay a $250 copay per day. Days 6+: You pay a $0 copay.	**In-Network** Days 1-7: You pay a $425 copay per day. Days 8+: You pay a $0 copay.
Meal Benefit GA Foods meal delivery following inpatient stay in a hospital or nursing facility.	**In-Network** You pay a $0 copay for a total of 14 meals. **Out-of-Network** Must use GA Foods.	Meal Benefit services are not covered.
Outpatient diagnostic tests and therapeutic services Radiological services	**In-Network** CT Scan or Nuclear Test: You pay a $190 copay per visit. PET Scan or MRI: You pay a $310 copay per visit.	**In-Network** CT Scan or Nuclear Test: You pay a $300 copay per visit. PET Scan or MRI: You pay a $400 copay per visit.
Outpatient Hospital, Observation, and Ambulatory Surgical Center services Excluding colonoscopies	**In-Network** You pay a $100 copay per visit.	**In-Network** You pay a $425 copay per visit.
Outpatient mental health care Including Psychiatric and counseling individual and group services	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay a $10 copay per visit.
Outpatient rehabilitation services Physical, occupational, and speech therapy	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay a $10 copay per visit.

Cost	2024 (this year)	2025 (next year)
Over-the-counter (OTC) medications NationsOTC	You get up to $100 per quarter to purchase OTC medications, and health related items.	You get up to $50 per quarter to purchase OTC medications, and health related items.
Part B Prescription Drugs: Prior Authorization and Step Therapy requirements	Requirements change yearly. Please contact Customer Service or see our Formulary to verify which drugs require prior authorization or step therapy.	Requirements change yearly. Please contact Customer Service or see our Formulary to verify which drugs require prior authorization or step therapy.
Physician/Practitioner services Primary Care, Specialist, and other health care professional service visits including transitional care and chronic care management services	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay a $10 copay per visit.
Podiatry services	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay a $10 copay per visit.
Urgently needed services Urgent care, including Worldwide coverage	You pay a $60 copay per visit.	You pay a $55 copay per visit.
Vision Care (Routine): Eye Wear	Up to a $250 reimbursement every calendar year.	Up to a $200 reimbursement every 2 calendar years.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in our plan

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 plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

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 2025* handbook, call your State Health Insurance Assistance Program (SHIP) (see Section 4), or call Medicare (see Section 6.2).

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

SECTION 3 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Oregon, the SHIP is called the Senior Health Insurance Benefits Assistance (SHIBA).

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 800-722-4134. You can learn more about SHIBA by visiting their website (www.OregonShiba.org).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. 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 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.

- **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. 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. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the CAREAssist Program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 971-673-0144. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

SECTION 6 Questions?

Section 6.1 – Getting Help from Our Plan

Questions? We're here to help. Please call Customer Service at 888-863-3637, TTY: 711. We accept all relay calls. We are available for phone calls: **October 1 - March 31:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. **April 1 - September 30:** 8:00 a.m. to 8:00 p.m. local time zone, Monday - Friday. Calls to these numbers are free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for our plan. 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.Medicare.PacificSource.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

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 6.2 – 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 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 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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/Pubs/pdf/10050-medicare-and-you.pdf) 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.