PacificSource Medicare

MyCare Choice Rx 29 (HMO-POS) *offered by* PacificSource Medicare

Annual Notice of Changes for 2024

You are currently enrolled as a member of MyCare Choice Rx 29 (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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).
- 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 2024 "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 2024* 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, 2023, you will stay in MyCare Choice Rx 29 (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, 2024**. This will end your enrollment with MyCare Choice Rx 29 (HMO-POS).
- 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

- Please contact our Customer Service number toll-free at 888-863-3637 for additional information (TTY users should call 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, 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 MyCare Choice Rx 29 (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). Enrollment in PacificSource Medicare depends on contract renewal.
- When this document says "we," "us," or "our", it means PacificSource Medicare. When it says "plan" or "our plan," it means MyCare Choice Rx 29 (HMO-POS).

Annual Notice of Changes for 2024 Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for our plan in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. 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** $5,200 **Out-of-Network** There is no maximum out-of-pocket amount for the services from out-of-network providers. The combined maximum out-of-pocket amount does not apply to this plan.	**In-Network** $5,200 **In-Network and Out-of-Network combined:** $8,950
Doctor office visits	**In-Network** Primary care visits: $0 per visit Specialist visits: $40 per visit **Out-of-Network** Primary care visits: $45 per visit Specialist visits: $45 per visit	**In-Network** Primary care visits: $0 per visit Specialist visits: $40 per visit **Out-of-Network** Primary care visits: $45 per visit Specialist visits: $45 per visit
Inpatient hospital stays	**In-Network** Days 1-5: $360 per day Days 6+: $0 per day **Out-of-Network** 50% of the total cost	**In-Network** Days 1-5: $360 per day Days 6+: $0 per day **Out-of-Network** 50% of the total cost

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $150 except for covered insulin products and most adult Part D vaccines. Copay/Coinsurance during the Initial Coverage Stage for up to a 30-day supply: • Drug Tier 1: Standard Cost-sharing: $8 Preferred Cost-sharing: $3 Preferred Mail Order Cost-sharing: $0 • Drug Tier 2: Standard Cost-sharing: $17 Preferred Cost-sharing: $12 • Drug Tier 3: Standard Cost-sharing: $47 Preferred Cost-sharing: $37 You pay $35 per month supply of each covered insulin product on this tier • Drug Tier 4: Standard Cost-sharing: 33% Preferred Cost-sharing: 31% • Drug Tier 5: Standard Cost-sharing: 30% Preferred Cost-sharing: 30% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: Standard Cost-sharing: $0 Preferred Cost-sharing: $0	Deductible: $150 except for covered insulin products and most adult Part D vaccines. Copay/Coinsurance during the Initial Coverage Stage for up to a 30-day supply: • Drug Tier 1: Standard Cost-sharing: $8 Preferred Cost-sharing: $3 Preferred Mail Order Cost-sharing: $0 • Drug Tier 2: Standard Cost-sharing: $17 Preferred Cost-sharing: $12 • Drug Tier 3: Standard Cost-sharing: $47 Preferred Cost-sharing: $42 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: Standard Cost-sharing: 33% Preferred Cost-sharing: 31% • Drug Tier 5: Standard Cost-sharing: 30% Preferred Cost-sharing: 30% You pay $35 per month supply of each covered insulin product on this tier. Drug Tier 6: Standard Cost-sharing: $0 Preferred Cost-sharing: $0

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 1.5 for details.)	Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called a coinsurance), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs).	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Monthly optional Comprehensive Dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$57	Not Applicable Optional Comprehensive Dental is <u>not</u> offered. Please see below for dental benefits covered on your plan.

- 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.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (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. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,200	$5,200 Once you have paid $5,200 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. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	There is no maximum out-of-pocket amount for the services from out-of-network providers. The combined maximum out-of-pocket amount does not apply to this plan.	$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 and Pharmacy Networks

Updated directories are located on our website at www.Medicare.PacificSource.com. You may also call Customer Service for updated provider and/or pharmacy 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 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies 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	2023 (this year)	2024 (next year)
24-Hour NurseLine	You pay a $0 copay per visit.	24-Hour NurseLine is not covered.
Cardiac Rehabilitation Services	**In-Network** You pay a $40 copay per visit.	**In-Network** You pay a $35 copay per visit.

Cost	2023 (this year)	2024 (next year)
Dental Services: Routine	The following services are covered up to a combined $1,500 annual maximum. You pay $0 for: • Routine Exams - 2 per year • Cleanings - 3 per year • Bitewing x-rays - 2 per year • Full mouth x-rays, Conebeam, and/or Panorex – 1 per 5 years You pay a 30% coinsurance for: • Pulpotomy • Tooth Desensitization • Pulp Capping • Oral Surgery (simple) • Stainless Steel Crowns • Core Build Up • Bone Grafting (Only covered at time of extraction or implant placement) • Fillings – 1 every 2 years • Root Planing/Perio Scaling – 1 every 2 years per quad • Debridement – 1 every 3 years not within 3 years of other prophy • Analgesia/Sedation Major Services are <u>not</u> covered.	The following services are covered up to a combined $1,500 annual maximum. You pay $0 for: • Routine and Problem-focused Exams • Cleanings • Bitewing x-rays • Full mouth x-rays, Conebeam and/or Panorex • Periapical X-ray • Brush biopsy • Fluoride and Fluoride Varnish You pay a 50% coinsurance for: • Pulpotomy • Tooth Desensitization • Pulp Capping • Oral Surgery (simple) • Core build up • Bone Grafting (Only covered at time of extraction or covered implant placement) • Fillings • Root Planing/Perio Scaling • Debridement • Analgesia/Sedation Stainless Steel Crowns are <u>not</u> covered. Major Services: You pay a 50% coinsurance for: • Crowns • Inlays and Onlays • Dentures • Bridges • Denture Relines • Implants • Veneers • Oral Surgery (complicated) • Periodontic Surgery • Root Canal Therapy

Cost	2023 (this year)	2024 (next year)
Emergency Care Post-Stabilization care, including Worldwide coverage	You pay a $110 copay per visit.	You pay a $120 copay per visit.
Medicare Part B prescription drugs Part B Insulin	**In-Network** You pay 20% of the total cost. Beginning July 2023, you pay 20% up to a $35 copay per insulin per month. **Out-of-Network** You pay 50% of the total cost. Beginning July 2023, you pay 50% up to a $35 copay per insulin per month.	**In-Network** You pay 20% up to a $35 copay per insulin per month. **Out-of-Network** You pay 50% up to a $35 copay per insulin per month.
Outpatient diagnostic tests and therapeutic services Lab services excluding A1c, ProTime Testing, and Genetic Testing	**In-Network** You pay a $40 copay per visit.	**In-Network** You pay a $0 copay per visit.
Outpatient Diagnostic Tests and Therapeutic Services: X-ray Services excluding Dexa Scans	**In-Network** You pay a $40 copay per visit.	**In-Network** You pay a $0 copay per visit.

Cost	2023 (this year)	2024 (next year)
Outpatient mental health care: Additional Mental Health Counselors	What you pay for services does not apply to your yearly maximum out-of-pocket amount.	What you pay for services applies to your yearly maximum out-of-pocket amount.
Outpatient rehabilitation services: Physical, Occupational, and Speech Therapy	**In-Network** You pay a $40 copay per visit.	**In-Network** You pay a $25 copay per visit.
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.
Prior Authorization Requirements: Inpatient Hospital Care; Inpatient Psychiatric Care; Outpatient Rehabilitation (Physical, Occupational, and Speech Therapy); Partial Hospitalization; Skilled Nursing Facility	**In-Network** Prior authorization is required.	**In-Network** Prior authorization is not required.
Pulmonary Rehabilitation Services	**In-Network** You pay a $20 copay per visit.	**In-Network** You pay a $15 copay per visit.

Cost	2023 (this year)	2024 (next year)
Skilled Nursing Facility	**In-Network** Days 1-20: You pay a $0 copay per visit. Days 21-100: You pay a $196 copay per visit.	**In-Network** Days 1-20: You pay a $0 copay per visit. Days 21-100: You pay a $203 copay per visit.
Supervised Exercise Therapy	**In-Network** You pay a $30 copay per visit.	**In-Network** You pay a $25 copay per visit.
Urgently needed services Urgent care, including Worldwide coverage	You pay a $40 copay per visit.	You pay a $60 copay per visit.
Vision Care (Routine) Eye exams	You pay a $0 copay per exam (1 exam every 2 calendar years).	You pay a $0 copay per exam (1 exam every calendar year).
Vision Care (Routine): Eye Wear	Up to a $200 reimbursement every 2 calendar years.	Up to a $200 reimbursement every calendar year.

Section 1.5 – 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", which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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 Customer Service for more information.

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 sent you 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 you haven't received this insert by September 30th, please call Customer Service and ask for the "LIS Rider."

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	2023 (this year)	2024 (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 doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $150. During this stage, you pay $8 at Standard cost-sharing and $3 at Preferred Retail cost-sharing, and $0 at Preferred Mail Order cost-sharing for drugs on Tier 1 Preferred Generic; $17 at Standard cost-sharing and $12 at Preferred cost-sharing for drugs on Tier 2 Generic; $0 at Standard and Preferred cost-sharing for drugs on Tier 6 Select Care Drugs and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty until you have reached the yearly deductible.	The deductible is $150. During this stage, you pay $8 at Standard cost-sharing and $3 at Preferred Retail cost-sharing, and $0 at Preferred Mail Order cost-sharing for drugs on Tier 1 Preferred Generic; $17 at Standard cost-sharing and $12 at Preferred cost-sharing for drugs on Tier 2 Generic; $0 at Standard and Preferred cost-sharing for drugs on Tier 6 Select Care Drugs and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (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 an in-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". Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply at an in-network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. **Tier 2 (Generic):** *Standard cost-sharing:* You pay $17 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $37 per prescription.	Your cost for a one-month supply at an in-network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. **Tier 2 (Generic):** *Standard cost-sharing:* You pay $17 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay $42 per prescription. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 4 (Non-Preferred Drug):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 31% of the total cost. **Tier 5 (Specialty):** *Standard cost-sharing:* You pay 30% of the total cost. *Preferred cost-sharing:* You pay 30% of the total cost. **Tier 6 (Select Care Drugs):** *Standard cost-sharing:* You pay $0 per prescription. *Preferred cost-sharing:* You pay $0 per prescription Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	**Tier 4 (Non-Preferred Drug):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 31% of the total cost. **Tier 5 (Specialty):** *Standard cost-sharing:* You pay 30% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay 30% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 (Select Care Drugs):** *Standard cost-sharing:* You pay $0 per prescription. *Preferred cost-sharing:* You pay $0 per prescription Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap 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.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*

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 be automatically 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 2024 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, please see Section 1.1 regarding 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 2024* handbook, call your State Health Insurance Assistance Program (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, 2024.

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, 2024, 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, 2024.

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 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 Montana, the SHIP is called the State Health and Insurance Assistance Program (SHIP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP 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 SHIP at 800-551-3191. You can learn more about SHIP by visiting their website (www.dphhs.mt.gov/sltc/aging/SHIP).

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 coverage gap or 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 (applications).

- **Help from your state's pharmaceutical assistance program.** Montana has a program called Big Sky Rx Program 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.
- **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 Montana AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

State:	Program:	Phone:
Montana	Montana AIDS Drug Assistance Program	406-444-3565

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 *2024 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 2024. For details, look in the *2024 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*) and our *List of Covered Drugs (Formulary/"Drug List")*.

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 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 2024***

Read the *Medicare & You 2024* 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.