# Essentials Choice Rx 24 (HMO-POS) *offered by* PacificSource Medicare

## Annual Notice of Changes for 2018

You are currently enrolled as a member of Essentials Choice Rx 24 (HMO-POS). 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, 1.2, and 1.5 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 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 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 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** Essentials Choice Rx 24 (HMO-POS), you don't need to do anything. You will stay in Essentials Choice Rx 24 (HMO-POS).
- 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 Essentials Choice Rx 24 (HMO-POS).
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

**Additional Resources**

- 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 Essentials Choice Rx 24 (HMO-POS)**

- 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 Essentials Choice Rx 24 (HMO-POS).

## Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Essentials Choice Rx 24 (HMO-POS) 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*** <br><br> * Your premium may be higher or lower than this amount. (See Section 2.1 for details.) | $76 | $74 |
| **Maximum out-of-pocket amount** <br> This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.) | From in-network providers: $5,500 <br><br> There is no maximum out-of-pocket amount for the amount you pay for services from out-of-network providers. The combined maximum out-of-pocket amount does not apply to this plan. | From in-network providers: $5,500 <br><br> There is no maximum out-of-pocket amount for the amount you pay for services from out-of-network providers. The combined maximum out-of-pocket amount does not apply to this plan. |
| **Doctor office visits** | **In-Network** <br> Primary care visits: $5 per visit <br><br> Specialist visits: $35 per visit <br><br> **Out-of-Network** <br> Primary care visits: 40% co-insurance per visit <br><br> Specialist visits: 40% coinsurance per visit | **In-Network** <br> Primary care visits: $0 per visit <br><br> Specialist visits: $35 per visit <br><br> **Out-of-Network** <br> Primary care visits: 50% co-insurance per visit <br><br> Specialist visits: 50% co-insurance per visit |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Inpatient hospital stays**<br>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**<br>Days 1-6:<br>$250 per day<br><br>Days 7+:<br>$0 per day<br><br>**Out-of-Network**<br>40% of the total cost. | **In-Network**<br>Days 1-4:<br>$400 per day<br><br>Days 5+:<br>$0 per day<br><br>**Out-of-Network**<br>50% of the total cost. |
| **Part D prescription drug coverage**<br>(See Section 2.6 for details.) | Deductible: $150 (applies to drugs in Tiers 3, 4, and 5) | Deductible: $150 (applies to drugs in Tiers 3, 4, and 5) |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| | Co-pays/co-insurance during the Initial Coverage Stage (up to a 30-day supply at an in-network retail pharmacy):<br>• **Drug Tier 1:** Standard cost-sharing: $6 Preferred Cost-sharing: $1<br>• **Drug Tier 2:** Standard cost-sharing: $17 Preferred Cost-sharing: $12<br>• **Drug Tier 3:** Standard cost-sharing: $47 Preferred Cost-sharing: $37<br>• **Drug Tier 4:** Standard cost-sharing: $100 Preferred Cost-sharing: $90<br>• **Drug Tier 5:** Standard cost-sharing: 30% Preferred Cost-sharing: 30%<br>• **Drug Tier 6:** Standard cost-sharing: $0 Preferred Cost-sharing: $0 | Co-pays/co-insurance during the Initial Coverage Stage (up to a 30-day supply at an in-network retail pharmacy):<br>• **Drug Tier 1:** Standard cost-sharing: $8 Preferred Cost-sharing: $3<br>• **Drug Tier 2:** Standard cost-sharing: $17 Preferred Cost-sharing: $12<br>• **Drug Tier 3:** Standard cost-sharing: $47 Preferred Cost-sharing: $37<br>• **Drug Tier 4:** Standard cost-sharing: 33% Preferred Cost-sharing: 31%<br>• **Drug Tier 5:** Standard cost-sharing: 30% Preferred Cost-sharing: 30%<br>• **Drug Tier 6:** Standard cost-sharing: $0 Preferred Cost-sharing: $0 |

# Annual Notice of Changes for 2018
# Table of Contents



## SECTION 1 We Are Changing the Plan's Name

On January 1, 2018, our plan name will change from Essentials Choice Rx 24 (HMO-POS) to MyCare Choice Rx 24 (HMO-POS).

The plan will mail a new member ID card to you by January 1, 2018. Please continue to use you current member ID card until December 31, 2017. Beginning January 1, 2018 all information sent to you by the plan will include your new plan name, MyCare Choice Rx 24 (HMO-POS).

## Section 1.1 – Changes to the Monthly Premium

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | $76 | $74 |
| **Monthly optional dental premium**<br>(This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.) | $22 | $22 |

- 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 enroll in Medicare prescription drug coverage in the future.
- 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.

## 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 amount, 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**<br>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 and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $5,500 | $5,500<br><br>Once you have paid $5,500 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 providers for the rest of the calendar year. |
| **Combined maximum out-of-pocket amount**<br>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 and 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 amount you pay for services from out-of-network providers. The combined maximum out-of-pocket amount does not apply to this plan. | There is no maximum out-of-pocket amount for the amount you pay for services from out-of-network providers. The combined maximum out-of-pocket amount does not apply to this plan. |

## 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 or email 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 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 in-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.Medicare.PacificSource.com. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network**.

## Section 1.5 – 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 2018 *Evidence of Coverage*.

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Ambulance Services** | You pay a $250 co-pay per one-way transport. | You pay a $300 co-pay per one-way transport. |
| **Annual Physical Exam** | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Cardiac Rehabilitation Services** (Including Intensive Cardiac Rehabilitation) | **In-network:** You pay a $30 co-pay per visit.<br><br>**Out-of-network:** You pay 40% of the total cost. | **In-network:** You pay a $35 co-pay per visit.<br><br>**Out-of-network:** You pay 50% of the total cost. |
| **Chiropractic Services** | **Out-of-network:** You pay 40% 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 40% 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. |
| **Hearing Services:** Medicare-covered | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Home Health Agency Care** | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Inpatient Hospital Care** | **In-network:**<br>Days 1-6:<br>You pay a $250 co-pay per day.<br><br>Days 7+:<br>You pay a $0 co-pay per day.<br><br>**Out-of-network:**<br>You pay 40% of the total cost. | **In-network:**<br>Days 1-4:<br>You pay a $400 co-pay per day.<br><br>Days 5+:<br>You pay a $0 co-pay per day.<br><br>**Out-of-network:**<br>You pay 50% of the total cost. |
| **Inpatient Mental Health Care** | **In-network:**<br>Days 1-6:<br>You pay a $250 co-pay per day.<br><br>Days 7+:<br>You pay a $0 co-pay per day.<br><br>**Out-of-network:**<br>You pay 40% of the total cost. | **In-network:**<br>Days 1-4:<br>You pay a $400 co-pay per day.<br><br>Days 5+:<br>You pay a $0 co-pay per day.<br><br>**Out-of-network:**<br>You pay 50% of the total cost. |
| **Medical Supplies** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Medicare Part B Prescription Drugs** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Medicare-covered Zero Dollar Preventive Services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Other Medicare-covered Preventive Services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Outpatient Blood Services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Outpatient Diagnostic Procedures and Tests** | **In-Network:**<br>You pay a $20 co-pay for each individual procedure and test.<br><br>**Out-of-Network:**<br>You pay 40% of the total cost. | **In-Network:**<br>You pay a $15 co-pay for each individual procedure and test.<br><br>**Out-of-Network:**<br>You pay 50% of the total cost. |
| **Outpatient Diagnostic radiological services** | **In-network**:<br>You pay 20% of the total cost.<br><br>**Out-of-Network:**<br>You pay 40% of the total cost. | **In-network**:<br>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<br><br>**Out-of-Network:**<br>You pay 50% of the total cost. |
| **Outpatient Lab Services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Outpatient Mental Health Care** | **In-Network:**<br>You pay a $35 co-pay per visit.<br><br>**Out-of-Network:**<br>You pay 40% of the total cost. | **In-Network:**<br>You pay a $20 co-pay per visit.<br><br>**Out-of-Network:**<br>You pay 50% of the total cost. |
| **Outpatient Rehabilitation Services:**<br>Occupational Therapy | **In-Network:**<br>You pay a $30 co-pay per type of therapy per visit.<br><br>**Out-of-Network:**<br>You pay 40% of the total cost. | **In-Network:**<br>You pay a $20 co-pay per type of therapy per visit.<br><br>**Out-of-Network:**<br>You pay 50% of the total cost. |
| **Outpatient Rehabilitation Services:**<br>Physical, and Speech Language Therapy | **In-Network:**<br>You pay a $30 co-pay per type of therapy per visit.<br><br>**Out-of-Network:**<br>You pay 40% of the total cost. | **In-Network:**<br>You pay a $35 co-pay per type of therapy per visit.<br><br>**Out-of-Network:**<br>You pay 50% of the total cost. |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Outpatient Substance Abuse Services** | **In-Network:**<br>You pay a $30 co-pay per visit.<br><br>**Out-of-network:**<br>You pay 40% of the total cost. | **In-Network:**<br>You pay a $35 co-pay per visit.<br><br>**Out-of-network:**<br>You pay 50% of the total cost. |
| **Outpatient Surgery**, including services provided at hospital outpatient facilities and ambulatory surgical centers | **In-Network**<br>Outpatient Hospital Facilities<br>You pay a $250 co-pay per visit.<br><br>Ambulatory Surgical Centers<br>You pay a $150 co-pay per visit.<br><br>**Out-of-Network**:<br>You pay 40% of the total cost. | **In-Network:**<br>You pay a $400 co-pay per visit.<br><br>**Out-of-Network:**<br>You pay 50% of the total cost. |
| **Outpatient Therapeutic radiological services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Outpatient X-ray services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Partial Hospitalization Services** | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>You pay 50% of the total cost. |
| **Physician/Practioner Services:**<br>Non-Routine Dental Care | **Out-of-network:**<br>You pay 40% of the total cost. | **Out-of-network:**<br>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 $5 co-pay per visit.<br><br>**Out-of-Network:** You pay 40% of the total cost. | **In-network:** PCP Office: You pay a $0 co-pay per visit.<br><br>**Out-of-Network:** You pay 50% of the total cost. |
| **Podiatry Services** | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Point of Service benefit limit** | The plan covers up to $5,000 per plan year for covered services you receive from out-of-network providers. | The plan covers up to $2,500 per plan year for covered services you receive from out-of-network providers. |
| **Prosthetic Devices and Related Supplies** | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Pulmonary Rehabilitation Services** | **Out-of-network:** You pay 40% 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 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Services to Treat Kidney Disease and Conditions:** Outpatient dialysis treatments | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Skilled Nursing Facility (SNF) Care** | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Sleep Studies** | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Urgently Needed Services** | You pay a $30 co-pay per visit. | You pay a $40 co-pay per visit. |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Vision Care:** Medicare-Covered Eye Exam | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |
| **Vision Care: Routine-** Refractive Eye Exams | **Out-of-network:** You pay 40% of the total cost. | **Out-of-network:** You pay 50% of the total cost. |

## Section 1.6 – 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 in this envelope.

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. **We encourage current members** to ask for an exception before next year.
    - 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 **one-time**, 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.

**Please note:** If you have previously received an approved formulary exception, you may need to request a renewal of that exception to continue receiving the medication in 2018. Please consult the drug list or contact Customer Service to ask if you need to receive a new coverage determination.

## 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 haven't received this insert bySeptember 30, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 8.1 of this booklet.

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 enclosed *Evidence of Coverage*.)

### Changes to the Deductible Stage

| Stage | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Stage 1: Yearly Deductible Stage**<br><br>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.<br><br>During this stage, you pay the following cost-sharing for a one month supply at an in-network pharmacy: Standard cost-sharing $6 per prescription; Preferred cost-sharing $1 per prescription for drugs on Tier 1 Preferred Generic, Standard cost-sharing $17 per prescription; Preferred cost-sharing $12 per prescription drugs on Tier 2 Generic, Standard cost-sharing $0 per prescription; Preferred cost-sharing $0 per prescription for drugs on Tier 6 Select Care drugs, and the full cost of the 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.<br><br>During this stage, you pay the following cost-sharing for a one month supply at an in-network pharmacy: Standard cost-sharing $8 per prescription; Preferred cost-sharing $3 per prescription for drugs on Tier 1 Preferred Generic, Standard cost-sharing $17 per prescription; Preferred cost-sharing $12 per prescription drugs on Tier 2 Generic, Standard cost-sharing $0 per prescription; Preferred cost-sharing $0 per prescription for drugs on Tier 6 Select Care drugs, and the full cost of the 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**

For drugs on Non-preferred drug tier (Tier 4), your cost-sharing in the initial coverage stage is changing from co-pay to co-insurance. Please see the following chart for the changes from 2017 to 2018.

To learn how co-payments and co-insurance 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 | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>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.**<br><br>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*.<br><br>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 an in-network pharmacy:<br><br>**Tier 1 (Preferred Generic):**<br>*Standard cost-sharing:* You pay $6 per prescription.<br>*Preferred cost-sharing:* you pay $1 per prescription.<br><br>**Tier 2 (Generic):**<br>*Standard cost-sharing:* You pay $17 per prescription.<br>*Preferred cost-sharing:* you pay $12 per prescription.<br><br>**Tier 3 (Preferred Brand):**<br>*Standard cost-sharing:* You pay $47 per prescription.<br>*Preferred cost-sharing:* you pay $37 per prescription.<br><br>**Tier 4 (Non-preferred drugs):**<br>*Standard cost-sharing:* You pay $100 per prescription.<br>*Preferred cost-sharing:* you pay $90 per prescription.<br><br>**Tier 5 (Specialty Tier):**<br>*Standard cost-sharing:* You pay 30% of the total cost.<br>*Preferred cost-sharing:* you pay 30% of the total cost.<br><br>**Tier 6 (Select Care Drugs):**<br>*Standard cost-sharing:* You pay $0 per prescription.<br>*Preferred cost-sharing:* you pay $0 of the total cost per prescription.<br><br>_____<br>Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage). | Your cost for a one-month supply at an in-network pharmacy:<br><br>**Tier 1 (Preferred Generic):**<br>*Standard cost-sharing:* You pay $8 per prescription.<br>*Preferred cost-sharing:* you pay $3 per prescription.<br><br>**Tier 2 (Generic):**<br>*Standard cost-sharing:* You pay $17 per prescription.<br>*Preferred cost-sharing:* you pay $12 per prescription.<br><br>**Tier 3 (Preferred Brand):**<br>*Standard cost-sharing:* You pay $47 per prescription.<br>*Preferred cost-sharing:* you pay $37 per prescription.<br><br>**Tier 4 (Non-preferred drugs):**<br><br>For 2017 you paid a $100 co-pay at a standard pharmacy and $90 co-pay at a preferred pharmacy.<br><br>For 2018 you will pay 33% co-insurance at a standard pharmacy and 31% co-insurance at a preferred pharmacy for drugs on this tier.<br><br>**Tier 5 (Specialty Tier):**<br>*Standard cost-sharing:* You pay 30% of the total cost.<br>*Preferred cost-sharing:* you pay 30% of the total cost.<br><br>**Tier 6 (Select Care Drugs):**<br>*Standard cost-sharing:* You pay $0 per prescription.<br>*Preferred cost-sharing:* you pay $0 of the total cost per prescription.<br><br>_____<br>Once your total drug costs have reached $3,750, 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**. For Initial Coverage Stage, for drugs on Tier 4, your cost-sharing is changing from a co-pay to co-insurance.

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

## SECTION 2 Administrative Changes

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Gap Coverage** | For select brand drugs in the Preferred Brand and Non-Preferred drug tiers (Tiers 3 and 4), your cost will not increase from Stage Two (Initial Coverage Stage). | For select brand drugs in the Preferred Brand tier (3), your cost will not increase from Stage Two (Initial Coverage Stage). |
| **Home Health prior authorization requirement** | Prior authorization required for Home Health Services | No prior authorization required for Home Health Services |
| **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 | TruHearing Flyte Advanced and Flyte Premium |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Part D Prescription Drugs: Prior Authorization requirements** | Prior authorization requirements for Part D drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part D drugs require prior authorization. | Prior authorization requirements for Part D drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part D drugs require prior authorization. |

# SECTION 3 Deciding Which Plan to Choose

## Section 3.1 – If you want to stay in MyCare Choice Rx 24 (HMO-POS)

**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 (see Section 6 or call Medicare (see Section 8.2).

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, our plan 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 MyCare Choice Rx 24 (HMO-POS).

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MyCare Choice Rx 24 (HMO-POS)
- 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 8.1
  - – *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 10, 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 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 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.

- 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, 24 hours 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).

- **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:
  - Idaho AIDS Drug Assistance Program

| 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 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 these numbers 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 MyCare Choice Rx 24 (HMO-POS). 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) 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 or (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 and click on "Find health & drug plans").

**Read *Medicare & You 2018*.**

You can read the *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.