PacificSource Medicare

Explorer 8 (PPO) *offered by* PacificSource Medicare

Annual Notice of Changes for 2019

You are currently enrolled as a member of Explorer 8 (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 and 2 for information about benefit and cost changes for our plan.

☐ 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 https://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 8 (PPO) you don't need to do anything. You will stay in Explorer 8 (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, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Explorer 8 (PPO).
- If you join another plan by December 7, 2018, your new coverage will start on January 1, 2019.

Additional Resources

- If you have a visual impairment and need this material in a different format such as Braille, large print, or audio tapes, 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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Explorer 8 (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 8 (PPO)

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Explorer 8 (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 *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium (See Section 1.1 for details.)	$48	$25
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: $6,700 From in-network and out-of-network providers combined: $10,000	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: $10 per visit Specialist visits: $35 per visit **Out-of-Network:** Primary care visits: 50% of the total cost per visit Specialist visits: 50% of the total cost per visit	**In-Network:** Primary care visits: $10 per visit Specialist visits: $35 per visit **Out-of-Network:** Primary care visits: 50% of the total cost per visit Specialist visits: 50% of the total cost 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: $285 per day Days 8+: $0 per day **Out-of-Network:** 15% of the total cost	**In-Network** Days 1-7: $285 per day Days 8+: $0 per day **Out-of-Network:** 40% of the total cost

Annual Notice of Changes for 2019

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$48	$25
Monthly optional dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$28	$28

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

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	2018 (this year)	2019 (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 plan premium does not count toward your maximum out-of-pocket amount.	$6,700	$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	2018 (this year)	2019 (next 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 plan premium does not count toward your maximum out-of-pocket amount.	$10,000	$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 2019 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 *2019 Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Additional Mental Health Counselors Licensed Professional Counselors (LPC), Licensed Clinical Professional Counselors (LCPC), Licensed Marital and Family Therapists (LMFT), and Licensed Mental Health Counselors (LMHC) are available as In-Network providers	Additional Mental Health Counselors are not covered	**In-Network:** You pay a $20 co-pay per visit **Out-of-Network:** You pay 50% of the total cost per visit
Alternative Care Acupuncture, naturopathy, and non-Medicare covered chiropractic care	Alternative Care is not covered	**In-Network:** You pay a $20 co-pay per visit up to a $450 combined benefit limit per calendar year.
Chronic Care Management Services: PCP or Specialist visit focusing on complex chronic care management services. These services include an assessment of medical and mental health needs, medication review, a comprehensive care plan and coordination of care.	**In-Network:** You pay a $10 co-pay per visit for PCP You pay a $35 co-pay per visit for specialist	**In-Network:** You pay a $0 co-pay per visit
Dexa Scan Bone density diagnostic screenings	**In-Network:** You pay a $15 co-pay per visit	**In-Network:** You pay a $0 co-pay per visit

Cost	2018 (this year)	2019 (next year)
Diagnostic Colonoscopy	**In-Network:** You pay a $285 co-pay per visit	**In-Network:** You pay a $0 co-pay per visit
Doctor Office visits Primary Care Provider (PCP) office visits for new or existing conditions when included with an annual wellness visit or annual routine physical visit.	**In-Network:** You pay a $10 co-pay per visit	**In-Network:** You pay a $0 co-pay when received in conjunction with annual wellness visit or annual routine physical exam with Primary Care Provider
Emergency Care	You pay a $80 co-pay per visit	You pay a $90 co-pay per visit
Health and Wellness Education Programs: The Silver&Fit® Exercise & Healthy Aging Program	$50 nonrefundable annual member fee to join a participating fitness center. Or, you can enroll into the Silver&Fit Home Fitness Program for a $10 annual member fee and receive up to two home fitness kits per benefit year.	$0 annual member fee to join a participating fitness center. Or, you can enroll into the Silver&Fit Home Fitness Program for $0 annual member fee and receive up to two home fitness kits per benefit year.
Inpatient Hospital Care	**Out-of-Network:** You pay 15% of the total cost	**Out-of-Network:** You pay 40% of the total cost
Inpatient Mental Health Care	**Out-of-Network:** You pay 15% of the total cost	**Out-of-Network:** You pay 50% of the total cost
Outpatient Diagnostic Tests and Lab Services: Genetic Testing	**In-Network:** You pay a $15 co-pay per test	**In-Network:** You pay 20% of the total cost per test

Cost	2018 (this year)	2019 (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 $167 co-pay per day	**In-Network:** Days 1-20: You pay a $0 co-pay per day. Days 21-100: You pay a $172 co-pay per day

Cost	2018 (this year)	2019 (next year)
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	Supervised Exercise Therapy is <u>not</u> covered.	**<u>In-Network:</u>** You pay a $30 co-pay per visit **<u>Out-of-Network:</u>** You pay 50% of the total cost per visit

Cost	2018 (this year)	2019 (next year)
Transitional Care Management Services: PCP or Specialist visit following discharge from one of these hospital settings: • Inpatient Acute Care Hospital • Inpatient Psychiatric Hospital • Long Term Care Hospital • Skilled Nursing Facility • Inpatient Rehabilitation Facility • Hospital outpatient observation or partial hospitalization • Partial hospitalization at a Community Mental Health Center	**In-Network:** You pay a $10 co-pay per visit for PCP You pay a $35 co-pay per visit for specialist	**In-Network:** You pay a $0 co-pay per visit
Vision Care: Routine (refractive) eye exams.	**Out-of-Network:** You pay 50% of the total cost per visit	**Out-of-Network:** You pay a $35 co-pay per visit

SECTION 2 Administrative Changes

Cost	2018 (this year)	2019 (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.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Explorer 8 (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 2019.

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 2019 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 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://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 8 (PPO).
    - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Explorer 8 (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, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 8, 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 Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (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 (800) 722-4134. You can learn more about SHIBA by visiting their website (www.OregonShiba.org).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

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

and don't even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **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 Oregon CAREAssist 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:**
Oregon	CAREAssist	(800) 805-2313

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

State:	**Program:**	**Phone:**
Oregon	CAREAssist	(800) 805-2313

SECTION 7 Questions?

Section 7.1 – Getting Help from Our Plan

Questions? We're here to help. Please call Customer Service at toll-free at (888) 863-3637. (TTY only, call (800) 735-2900.) 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 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Explorer

8 (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. Information on where to access 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 (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 (https://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 https://www.medicare.gov and click on “Find health & drug plans.”)

Read *Medicare & You 2019*

You can read *Medicare & You 2019* 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 (https://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.